PUBLIC HEALTH NURSING

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PURCELLE PECK, R.N.
EDITOR

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PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

Courtesy of "All the Children"

SHARING HEALTH INFORMATION WITH THE TEACHER

"TAKE THE TEACHERS into your confidence," certain educators have been telling us for some years. "Give them the health information you have about the children. Secure from them their observations about the pupils. Interpret to them the health needs of the children in nontechnical language. Then and only then will you make real progress in solving the problems of the individual child and helping all of the children to achieve optimal health."

Too often the health personnel—physician and nurse and others—sit in their own department surrounded by records on which is noted significant information that the teacher needs: medical data from the health examinations; vital information on the home situation which the nurse has secured in her visits to parents. True, data are available to the teacher upon request, and perhaps the nurse has conferences with her in regard to individual children

whose problems obviously demand attention. But the teacher is a busy person, and actually a large part of the important medical and social information about the children remains forever unknown to her unless there is definite provision in the program for seeing that she gets it.

Similarly, the teacher's contribution to the sum total of health knowledge about the child is invaluable to the health personnel. Certainly she is the one person in the school who is most intimately and continuously in touch with the child. She sees him throughout the day—when he is not putting on his best front for a health inspection; when he is reacting to other children and to the entire school situation; when he is fatigued; when he is relaxed. Upon her keenness in observation of symptoms depends the early discovery of incipient illness, and the detection of health problems at the stage when they can still be effectively forestalled or treated.

The teacher is the person responsible for maintaining a healthful school regimen and environment—both physical and emotional—which will be favorable to the children's health. She needs to be aware of the individual and collective needs of her class. It is important for her to know that Jimmy is the product of a chaotic and unhappy home; that Robert's mother is having a struggle to feed the children adequately on a marginal budget; that Mary's home is too noisy and congested for homework in the evening. She should be sensitive to the presence of children who tire easily, who are unduly shy, who have frequent digestive upsets. Even in a crowded room, certain modifications of regimen can be made to meet the needs of these children.

It behooves her to know if she has a large proportion of vision defects in her class, so that special consideration may be given to the lighting and to the amount of close work done by the children. She should know if she has a high percentage of children with a history of frequent colds, indicating the need for unusually strict precautions to prevent the spread of infection, to watch the ventilation and temperature of the room, and to avoid undue fatigue.

Moreover, it is the teacher who is responsible for an integrated health-education program for her class, a program starting from the point of their interests and based on their needs. She needs, therefore, a health picture of her room as a whole, showing the points where greatest emphasis is needed. Such a picture can come only from a pooling of the information of all those who work with the children.

How shall the significant information about the children be shared by all who are interested in them? How shall the knowledge of doctor and nurse and other health personnel be interpreted to the teacher; the teacher's observations be made known to the health personnel?

Various people interested in school health have developed ways of collecting and sharing all of the available health data about the child. The chief drawback to most of these plans is that they are too time-consuming.

In view of this problem, our readers will be keenly interested in the technique for interpretation and coördination which has been worked out in the School Health Study in Astoria, New York. (Page 476.) This plan, which actually "works" in a large city school system—with all that implies in case-loads and teacher-loads and complex community situations—should be even more easily applicable in a simpler situation. It is welcomed as a step toward the coördination of efforts of all the school personnel who are working toward the best possible health for all children.

Health for the Rural Child

By NINA B. LAMKIN

Practical suggestions of ways in which the nurse can be of help to the teachers in developing an effective health education program in rural schools*

HOW CAN the teachers with whom the public health nurse is working discuss their health problems? How can the nurse help them to do something about these problems?

It is assumed that the nurse knows quite in detail about the school curriculum, and the activities developing through the daily school program in her area. She knows something about the personality of each teacher; her health status; her relationship with her pupils, with the other teachers, and with the parents of her pupils. The teacher wants to help the boys and girls to get the most out of school life, and use the knowledges and practices which are developed at school for improved home and community living.

We believe that healthful living means the understanding and the daily practice of desirable ways of living in a good environment. The goals to be reached are optimal health, achievement, and happiness for the individual child, the teacher, and the parents in the home. A health education program developed along these lines is practical and worth while, because it is built around the needs and interests of the individual, and makes use of all opportunities for teaching and learning in the school environment, in the curriculum, and in the home and community.

The well prepared nurse sees the whole child in the total environment of school, home, and community. She will be able to make use of the various factors in different situations, and help the teacher to interpret the findings which are the results of her own observations and of tangible data which the nurse may have gathered.

THE FIRST VISIT

Let us consider a nurse's first visit to a certain rural school in her area. It is a friendly visit, to get acquainted with teachers and pupils. From now on they will consider the nurse a part of their school family. On this first visit she observes the lighting, seating, temperature, and ventilation. She is sensitive to the cleanliness of the room, the appearance of the children, and the general atmosphere of the school—whether it is happy and interesting or the reverse. She observes that there is hand-washing equipment. She learns that water has to be brought several miles from the mountains. The teacher and children take turns bringing this water; sometimes the fathers help.

There was no money with which to buy equipment either for hand-washing or for drinking purposes, but the enterprising teacher has worked this problem out with the boys and girls and the parents. The school is using two lard pails contributed by the corner groceryman, who is much interested in the plans, and one of the mothers has donated a gourd dipper. This is the hand-washing

*The practical helps described in this article represent the real adventures of nurses and teachers in a certain area in the Southwest where almost all of the nurses are carrying on generalized programs.

equipment. The children take turns—a committee is appointed each week—in pouring the water over soapy hands. The liquid soap has been made at school from bits of soap brought from home. It is kept in a large bottle from which a smaller one is filled each day. The towels are clean cloths brought from home. The waste water collected in one of the pails is carried to the schoolyard and poured around one of the trees which the boys and girls are caring for.

The water for drinking is kept in two large bottles which were donated by a druggist in a nearby town. Each child has his own cup or glass brought from home. Sometimes it is a small tin can with smooth edges, or a glass in which meat or jelly has been purchased. Again it is a real cup which the family could spare. Each cup is marked with the initials of the owner.

FINDING SOME OF THE NEEDS

The nurse is pleased with what has been accomplished. Her approval means much to the teacher and to the children. She inquires whether the teacher has helped the boys and girls to understand why hand-washing is so very important. No, the teacher was not sure just how to explain it in an interesting way. The nurse has the setting for a simple but valuable discussion with the group. After getting all the leads she can from them, she supplies the needed information, with interesting and practical comments, in terms of their understanding and experience.

Has the drinking water been tested? No, "it comes from a spring so it must be pure." Here is another opportunity for teaching and learning. The nurse helps them to take steps to have the water tested.

She will find other problems as she talks with the teacher and the group. This may be the time when they would like to continue the study of certain practices which will help to keep them well, free from communicable disease, and therefore better ready for work and play. Some of these practices would be:

To try to keep from having colds.

To report the first signs of a cold to the teacher and parents, and to know how to care for a cold.

To report at school any illness in the family.

To try to have safe water and safe milk.

To help eliminate fly-breeding places and flies at school and at home.

To help destroy any mosquito-breeding places in the community.

To wash properly the dishes used by ill persons in the home.

To know how to keep individual drinking cups clean.

To learn how to use the toilets in the right way and to keep them clean.

To care properly for garbage in the home and after lunch at school.

To avoid exchanging food, pencils, or drinking cups with others.

To help with the health program by being ready for morning inspection.

To learn ways to protect the members of the family when one has a communicable disease.

WORKING OUT A PROBLEM

The nurse may take one of these problems which the teacher believes is very important in her particular situation and help her to plan ways of solving it through teacher-pupil-parent planning and through shared responsibility. Take for example the objective, "To try to keep from having colds." What is a cold and how does one "catch cold?" What background of scientific facts will the boys and girls need to help them understand the "why" of a cold? The nurse may have a pamphlet which she can give the teacher, to help answer this question; it may contain facts simply told, such as:

Colds are probably caused by germs so small that they cannot be seen even under the microscope. These are called viruses. We are exposed to such germs very frequently. Whether we "catch cold" depends upon our own bodily resistance as well as upon the presence of the germs. . . Regular sleep and

rest, regular outdoor exercise, especially in the sunshine, a balanced diet including plenty of milk, fruits, and vegetables, and plenty of drinking water will all help one to resist colds.*

What can the nurse suggest in the way of practical activities which may help the group to have fewer colds than formerly? The teacher may be encouraged to discuss this problem with the children and get from them what they think they could do. Their ideas may be supplemented with practical suggestions which are feasible. One such discussion led to this list:

Getting enough sleep for our age, in a bed or cot by ourselves.

Getting all the fresh air possible.

Eating a good breakfast before coming to school.

Bringing a reasonably adequate lunch.

Having something hot for lunch in winter.

Playing in the open air and sunshine all we can

Keeping the temperature and ventilation "good" at home and at school.

Having the stove jacketed and not sitting too near it.

Helping to keep a moderate fire—rather than having a very hot one at times and then letting the room get cold.

Talking our problem over at home and asking our parents to help us in working out our activities.

Each of these situations presents certain problems which in turn need consideration. The teacher has a series of related problems which will last through the school term. She has friendly contact with the parents and will ask them to discuss with her what they can all do, working together to have fewer colds. One father made his six-year-old daughter a cot out of scraps of wood and a piece of ticking, at the suggestion of the nurse and teacher, so that she could sleep alone. Before the year was out this father had made four cots and each child slept alone, with the result that all slept better and colds were not so easily passed around.

*Wood, Phelan, Lerrigo, Lamkin, and Rice. How We Live. Adventures in Living series. Thomas Nelson and Sons, New York, 1936, p. 129.

"WHAT TO DO"

"What to do when one has a cold" is another question that the pupils may want to consider. The time for discussing this problem is when some of the children have colds. The following activities were planned by one teacher and group with help from the nurse:

To stay away from others when one has a cold.

To ask the doctor's advice and not take drugs and laxatives suggested by the neighbors.

To report to parents the first signs of a cold or illness.

To remain home until recovered from the cold.

To sleep alone.

To cough and sneeze into one's handkerchief, or into a paper handkerchief which will be burned.

To blow the nose gently in order to avoid forcing the infectious discharge into the sinuses.

To wash the hands before handling food, or anything belonging to others.

To boil one's dishes before anyone else uses them.

The nurse may suggest that the children keep records of how each problem works out, so that they can see the tangible results and draw their own conclusions as to the value of the behaviors they have practiced.

In developing teacher-pupil activities with shared responsibility, the suggestion may be made that the pupils find answers to their questions in the health textbook and in as many other sources of information as the teacher can arrange for. Each room should have a reading table with free and inexpensive materials which the nurse can suggest. The teacher will keep all the questions of the pupils concerning any of the problems. These are leads showing their interests in terms of their own thinking. They reveal individual differences and right and wrong concepts. The teacher needs authoritative material in order to discuss the questions with the children. The nurse can help her to help them think clearly and intelligently on their problems.

QUESTIONS FROM TEACHERS

The nurse will find clues, to many basic problems, in teachers' questions. They represent the problems as the teachers see them at the present time. In suggesting the study and the possible solution of these and other problems the nurse has excellent opportunities for teaching. The questions are valuable and should be kept. Following are ten questions from teachers in average rural schools and suggestions that were given by the nurse, or by the school health consultant.

1. *What would you do with a listless child who takes no interest in his school work? He has much to do at home.*

Your question suggests that the child is fatigued, and when one is greatly fatigued, no work or play is interesting. The child may not be well; this is the first thing to consider and remedy if possible. Fatigue may be the result of not having sufficient nourishing food; of too much work expected of the child at home; or of a poor sleeping situation, such as sleeping in crowded quarters and without fresh air. Another cause may be not getting enough sleep for his age. Perhaps you can talk to his parents about having him examined by a doctor, with one or both of them present. You may be able to lighten his work; to have him rest while others are playing; to have him work less at home. Probably there are many things to be done to help a child with this handicap. There is a reason, let us find it if we can.

2. *I need play activities for a small rural school, including all grades and mostly boys.*

Your boys can get orange-crating and make a target and a beanbag board. Out of scraps of wood from the woodpile they can make a standard for ringtoss; out of fourteen-inch lengths of rope they can make rings to throw over the standard. Other pieces of wood of different shapes and sizes from the woodpile make blocks for the younger children. Twenty cents worth of bright enamel will paint the blocks, target, and ringtoss standard. Stocking balls are enjoyed by the younger children. The others can make balls out of inner tubes cut round and round in quarter-inch width and wound into balls of varying sizes which bound higher than the head, and which can be used at the target and beanbag board as well as in many other games. Some of the mothers will find denim and ticking in their "piece bags" for the beanbags. Each pupil can bring a handful of beans or corn to fill the bags one-third full.

One school where the main activity at recess was fighting, because there was nothing with which to play, now has 20 balls made of inner tubes. Many problems of discipline have disappeared with the coming of organized play and pupil leadership with teacher guidance.

Home play needs encouragement also. As fathers and mothers get interested in trying out their skill, family relationships improve.

3. *How can I correlate health teaching with the social sciences?*

The social sciences—on different age-levels—have to do with different areas of living, such as: securing food, shelter, and clothing; transportation of people and goods; communication with one another; earning a living; conserving human resources; and coöperating in social and civic activities. Each of these areas presents real situations in which people live and do things; in each, natural health implications are present. For example, the subject of securing food, shelter, and clothing offers many opportunities to study how to use our environment for obtaining these necessities of life, and what practices we engage in—such as food practices and behaviors in regard to clothing. In a study of transportation of people and goods there is an opportunity to study measures for public health and safety in our community. In the problem of conserving human resources we not only think of

safety, but of the control of communicable disease and other health problems.

4. *How can I get the practice of using individual drinking cups to carry over into the home?*

When you have helped the children to practice this behavior with pleasure and satisfaction; when they know why it is important and how to keep the cups clean with hot soapsuds; when the parents have had the whole matter explained to them and their help has been given and appreciated—you have a good setting to carry over the practice to home and community life. When one is convinced that a certain practice is worth while for him, there is usually a change in attitude and behavior.

5. *I have a pupil who has no pride in his appearance and he is shunned by all his playmates. How can I help him?*

Find something that this boy is interested in doing and build on it.

Tom liked to play a drum more than to engage in any other activity. The teacher made him drummer boy for the school; he played his drum when the pupils entered the building in the morning. The first morning after his appointment he came to school with his hair combed, and with clean clothes and a radiant smile. He had been the most unkempt boy in school.

James, with whom the nurse and teacher had tried hard to plan more cleanly practices, seemed hopeless. One day the nurse asked this 15-year-old boy what he was going to do when school was out. "I'm going to get a job in the flour mill or the place where they grind horse feed." These were the two industries in the community. "But James, you'll have to be clean to get a job," said the nurse. "Oh, no, I won't," he answered. A few days later he came to school quite clean, much to the surprise of the teacher and others. His teacher was pleased with his appearance and told him so. "Well," said James, "I inquired at the flour mill and the horse-feed mill about a job and at both places they said I had to be clean to work for them."

6. *We have a hot-lunch problem. Children bring lunches that are not nourishing. What can I do to remedy this situation and supplement the lunch from home?*

This is a problem in regard to growth. I will help you to weigh and measure the children the first time and show you how they can each keep individual records of growth from month to month. This is a tangible basis for working out problems in regard to foods, hours of sleep, more play in the air and sunshine, and other health practices. In addition to weighing the children every month you will want to observe them in their work and play. You will probably want to keep some records of individual children as you see them improve.

The hot dish for lunch can be worked out in several ways. Each child can bring a cooked vegetable in a small glass can with a screw top. Loosen the tops, set the cans on a wire rack in a pan of water on your stove, and have this vegetable hot at lunch time. Hot soup or hot cocoa can be planned for with children and parents. The choice of food, preparation of vegetables, cooking, and serving can all be a part of your project.

7. *What sort of a project in health can a one-room rural school carry on?*

Any suggestions already given can be used in a one-room rural school, and each boy and girl will find something interesting to do. In addition, there are many other problems to work out, such as:

Preparing for the school day; getting enough sleep; dressing for the weather; eating a good breakfast.

Safety on the bus and on the highway.

Use of all the school facilities in the best possible way.

Making the playground safe for play; getting rid of stones, broken glass, holes, nails, and other hazards.

Learning about foods that help one to grow; visiting the roadside market; choosing foods; what to buy and why.

8. *What would you do with the child who will not play with others?*

A normal child likes to play. Find out why he does not want to play. He may not be well; he may be very timid; or he may have a home difficulty. The young child is often very timid and only gradually learns to be a social person. At first he may play with one friend of his own choosing and later on when he has gained some confidence in himself he will join others in play. Gradually in a friendly way find the reasons why he does not want to play and remove them if you can. Give such a boy or girl some responsibility for a group of younger children. When he plays with one or two companions of his choosing, they will probably be those who have about the same ability in skills that he has. With these companions he can achieve some degree of success. This will give him courage.

9. *I have a child who is most annoying. I thrash him but it does not seem to help. What else can I do?*

"Problems" like this one need to be studied, not thrashed. There is a cause for every effect; the question is to learn the cause. We will find out what we can about the home situation; the relationships between members of the family; the economic status of the family. On the basis of this information we will try to interpret the behaviors of the child in school and on the playground. Is he well? Can a medical examination be arranged? What about his food, rest, and other health practices?

George became irritable shortly after the other children had eaten lunch each day. On investigation it was found that he was sent to school without breakfast and that he brought no lunch with him. When adequate food was provided, his annoying behaviors disappeared.

Robert had a most unhappy home. He was punished nearly every day and of course was unhappy in school as a result. Gradually through the efforts of the teacher—guided by the nurse who also visited the home—the family became interested in helping the boy to have some things to play with at home. They brought him into family discussions and gave him some responsibility in the family life. His father took him fishing, a thing he had never done before. Life became more interesting because Robert felt now that he belonged in the family and that his mother and father cared about him. The teacher found many ways to make his school day happier and more worth while to him.

10. *How often should a nurse be asked to visit a school?*

The nurse plans in her schedule for her visit to each school. She will tell you how many schools she has in her area and about how often she expects to visit each school unless emergencies compel her to change her plans. When she goes to your school she has in mind your particular problems and helps you to look ahead and plan the next steps.

SUMMARIZING THE NURSE'S HELP

The nurse is the health counselor. She must be capable of advising from an educational viewpoint; then every situation becomes one for both teaching and learning.

She helps the school to survey and to improve the environment, without cost if necessary. There is always something that can be done.

She suggests better ways of using the school facilities for healthful living.

She helps the teacher to appreciate the value of a medical check-up and the physician's advice; the value of immunization as a teaching situation; the dangers of self-medication. (One teacher kept aspirin at her desk and gave it

out freely to any child who had a headache or other pain.)

She helps the teacher to use the information gained from the medical inspection; from visits to the home; from weighing and measuring; from morning inspection for observations of first symptoms of illness; from observation of the children's behaviors in school and on the playground—in planning teacher-pupil activities with shared responsibility and parent coöperation.

She provides sources of authentic health materials when needed.

She helps the teacher to study retarded children and those with problems and to find ways of helping them by learning some of the causes of their handicaps.

She suggests how a school can have some inexpensive play equipment and helps the teacher to appreciate the educational values of play and a safe playground.

She helps the teacher to apply the principles of teaching to health problems. Some examples are suggested:

Present the positive side of a problem, not the negative side.

Give the child an understanding of each problem according to his age-level and past experience. "Why is it worth while for me?"

Remember that we are teaching boys and girls, not subject matter.

Give boys and girls opportunities to practice desirable behaviors with some degree of pleasure and satisfaction, because in this way one is more apt to learn.

Use the natural situations that occur in the school day, in the curriculum activities, and in the home and community, to teach better ways of doing those things which one would do anyway.

The best incentives for anyone are encouragement, approval, and help when one needs it—not gold stars and other extraneous awards.

Consider individual differences in children. No two children are alike so how can they be compared?

Working for 100 percent attendance is against all the best principles of teaching. This pernicious practice may bring on an epidemic. "Be in school every day that you are well," is a practice followed in some schools in considering attendance.

The less we think of health education as a separate subject in the elementary grades and the more we help the teacher to develop healthful living as a part of all activities in school, home, and community, the sooner we shall have a flexible health education program built around interests and needs and the best use of the environment for optimal health, achievement, and happiness.

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Lamkin, Nina B. Healthful Living Through the School Day and in Home and Community. Bulletin No. 1 of Healthful Living Series. State Department of Public Health, Santa Fe, New Mexico, 1939. Methods and materials for use in natural situations through the school day and at other times. Single copy free.

Metropolitan Life Insurance Company. Accident Prevention in the Home. The Company, 1 Madison Avenue, New York, 1935. Good material for a safety unit. Single copy free.

National Dairy Council. Enjoying a Well-Chosen Lunch. The Council, 307 North Michigan Avenue, Chicago. Leaflet 12c. Poster 10c.

National Education Association. Fit to Teach. Ninth Yearbook Department of Class-

room Teachers. The Association, 1201 Sixteenth Street, Washington, D.C., 1938. A study of health problems of teachers. $1.

National Recreation Association. Homemade Play Apparatus. The Association, 315 Fourth Avenue, New York, 1929. 25c.

National Recreation Association. The Home Playground and Indoor Playroom. The Association, 315 Fourth Avenue, New York, 1939. 20c.

National Section on Women's Athletics of the American Association for Health, Physical Education, and Recreation. Recreation Games and Sports. A. S. Barnes and Company, New York, 1938. Tells you how to make equipment for many games. 25c.

Ryan, W. Carson, Jr. Mental Health Through Education. The Commonwealth Fund, 40 East 57 Street, New York, 1938. $1.50.

Smith, Mary Emma. A Program of Eye Health in a School System. National Society for the Prevention of Blindness, 50 West 50 Street, New York, 1934. An outline for the guidance of school systems. 10c.

Wood, Phelan, Lerrigo, Lamkin, and Rice. Adventures in Living. This series consists of the following—Now We Are Growing (60c), Many Ways of Living (60c), Keeping Fit (72c), Blazing the Trail (80c), and How We Live (80c). Thomas Nelson and Sons, New York, 1936.

The N.T.A. Meets in Boston

THE ANNUAL MEETING of the National Tuberculosis Association, which took place in Boston, Massachusetts, during the week of June 25 was the biggest—and according to many regular attendants one of the best—of the thirty-five conventions held by the Association since it was founded in 1904. Over fifteen hundred people registered during the meetings.

Boston hospitality was evidenced in many delightful ways which enabled the visitors to see places of historical interest, listen to a summer "Pops" concert given by the Boston Symphony Orchestra, and even to partake of the famous Boston baked beans—miniature jars of which appeared in the hotel rooms of all registrants. On further investigation, however, the "beans" proved to be peanut candy in disguise.

The program itself included several novel features and much of special interest to nurses. One successful innovation was the series of clinics arranged during one afternoon, not only for physicians but for lay people as well. Lay clinics included one on rehabilitation, one on statistical methods, and three on different aspects of health education.

A session on June 28 was devoted almost exclusively to tuberculosis as related to nursing. The occurrence of tuberculosis among student nurses and ways of protecting them comprised one part of the discussion. A shorter working day and postponement of experience in the tuberculosis wards until the third year of student education were mentioned as recent changes in nursing school procedure which have helped to prevent occurrence of the disease. Other preventive measures emphasized were: the use of communicable disease technique by nurses caring for tuberculous patients; the taking of chest x-rays of all patients entering hospitals; the repeated x-raying of the student nurse herself; and the teaching of patients to protect those who care for them, by covering their coughs.

The importance of the nurse in tuberculosis control in her capacity as home visitor and teacher was recognized both at this session and by many speakers at other times. The need for better preparation both in teaching methods and in the knowledge of tuberculosis was stressed; also the fact that lack of coördination of the nurse's work

in the home with that of the physician in the clinic frequently hinders maximum accomplishment.

A joint symposium for all sections on "The Present Status of Mass Tuberculin-Testing and X-ray" was the last session of the convention. This much discussed topic was reviewed from various angles by nationally known authorities. Space does not permit even a summary here but nurses will be particularly interested in these papers when they appear in the transactions.

All speakers agreed on the great value of both the tuberculin test and the x-ray as methods leading to the detection of pulmonary tuberculosis. The x-ray in the opinion of these authorities is the best single method of early diagnosis but it is expensive and by itself is not perfect; it should be supplemented by the tuberculin test. Lesions shown in x-ray pictures may be due to causes other than tuberculosis. Also, tuberculous lesions in the lungs are sometimes hidden by other organs. It is significant that, according to Dr. Esmond R. Long, "Practically all clinical cases of pulmonary tuberculosis in man are positive to the tuberculin test." Hence, the test forms an excellent adjunct to the x-ray in diagnosis. Indeed, it is thought that great caution should be used in diagnosing pulmonary tuberculosis in the absence of a positive tuberculin test.

Statements frequently heard at this annual meeting were these: Tuberculosis can be eradicated. Tuberculosis is still one of the nation's most serious health problems. There is need for better preparation of all types of tuberculosis workers—physicians, health educators, and nurses. Perhaps these statements are really the keynotes not only of this convention but of the tuberculosis movement as a whole at this time.

R. H.

NURSE PLACEMENT SERVICE

N·P·S CHICAGO

announces the following placements from among appointments made in the various fields of public health nursing. As is our custom, consent to publish these has been secured in each case from both nurse and employer.

Florence Whipple, Supervisor of Public Health Nursing, State Board of Health, Helena, Mont.

Amy MacOwan, Executive Director, Starr Health Centre, Philadelphia, Pa.

Reba Edwards, Field Teacher and Supervisor of Public Health Nursing, Indiana University, Bloomington, Ind.

Eileen Dixon, Supervisor, Instructive Visiting Nurse Society, Washington, D.C.

Mrs. Eunice Diggle, Community Nurse, Maywood, Ill.

Mrs. Helene Dunham, Staff Nurse, Chicago Maternity Center, Chicago, Ill.

Mrs. Marie Schroeder, Staff Nurse, Tuberculosis Institute of Chicago and Cook County, Chicago, Ill.

Inie Olson, Camp Nurse, University of Chicago Settlement, Chesterton, Ind.

Celia Smith, Camp Nurse, Camp Fire Girls' Camp, South Haven, Mich.

Mrs. Laura Freshman, Camp Nurse, Camp Strongheart, Lake Tomahawk, Wis.

Charlotte Plohr, Camp Reinberg, Palatine, Ill.

Helen Binz, Camp Nurse, Y.W.C.A. Camp, Burlington, Vt.

ASSISTED PLACEMENTS

Marion Ballantyne, Orthopedic Nurse Consultant, State Department of Public Welfare, Albuquerque, N. Mex.

Mrs. Cynthia Hahn, Staff Nurse, Community Centre of Media and Vicinity, Media, Pa.

Modern Tools for School Health

By MARIAN V. FEGLEY, R.N.

Through an improvement in working tools and working relationships even the school with budgetary limitations can provide a better health service for its children

MANY EXPERTS in the fields of nursing and education have stressed the importance of individualized guidance in the health of children and have pointed out the responsibility of the teacher and nurse for giving such guidance. Unquestionably this is as it should be. But let us look at the facts. Only in communities having adequate facilities and personnel and where the teaching load of the teacher or the case load of the nurse is relatively small is the practice of such individualized guidance possible. This being so, the problem in the school of attaining the best health service for the child becomes one of coping with realities. When the staff is limited, added increments in efficiency are needed. These can come through two channels, the improvement of working tools and the improvement in working relationships.

If the objectives of health education include the development of healthy, efficient personalities and the preparation of children to meet successfully their individual opportunities and responsibilities, the school health staff must have at hand adequate tools and information to reach these objectives.

Tools, whether physical, mental, or mechanical, are needed in any undertaking, and some are better than others. The tractor is more efficient than the hand-plow. Similarly, tools must be devised to aid in developing a health service which is commensurate with the progress in other fields. But the tractor left standing idle is of no value and becomes merely a showpiece. The same is true of any tool developed to improve the school health service. This article will describe the development of new working tools in one school situation and the way in which they are used.

ASTORIA SCHOOL HEALTH STUDY

In New York City where the administration of the school health program is the joint responsibility of the Department of Health and the Board of Education, a study of school health problems has been conducted by both departments during the past three years. A staff of consultants, financed through funds obtained from outside sources, has worked with the medical, nursing, and teaching personnel of the city to improve techniques of work in their respective fields. Eight schools in the Astoria Health District of the city with an enrollment of 8500 children have served as the laboratory. Here studies have been made to locate the weak links in the work. Here new ways of utilizing staff time have been explored; new procedures in examining children have been tried out; new methods in staff education have been weighed in terms of the changes they produce in the attitudes and work habits of the staff. No detail of the daily work of the physician, nurse, or teacher has been taken for granted. Each has been scrutinized for its value in reaching the objective—*educational guidance in health for the child.*

Out of this wealth of experimental

material the Astoria study is precipitating definite practical aids which have demonstrable value. This article is concerned only with presenting one of the tools which we have found advantageous and some of the ways in which we use this tool to bring about more satisfactory ways of coördinating the efforts of the nurse, physician, and teacher.

From a single medical record used by physician and nurse the study has progressed to a health inventory sheet used by teacher and nurse, and finally to the development of two individual records, each new in its approach to the child's health problems. These two records for each child—one used by physician and nurse, the other used primarily by the teacher—furnish the answers to the "how," "when," and "by whom," of coöperation.

The medical record used by the physician and nurse—which is kept in the nurse's office—will not be described in detail here. Suffice it to state that it emphasizes the child's developmental history, his current health and behavior history, details of diagnosis, and specific recommendations for the action to be taken by the parent, nurse, and teacher. It is used in conjunction with the second record, the Health Card, which is the joint record of teacher, nurse, and physician, and is kept by the teacher in her classroom. Through the use of this record new and better techniques have evolved for the "class conference" between the teacher and nurse. In this conference, which is described later, the nurse goes to the classroom by appointment, and teacher and nurse together go over each individual child's records and select children for further medical care.[1] It is distinguished from the more frequent teacher-nurse conference on the needs of certain individual children.

Neither records nor conference techniques have sprung up in their present state. Both have been derived from painstaking experimental work—frequent revision of the records, countless discussions by the professional staff on the content of a class conference.

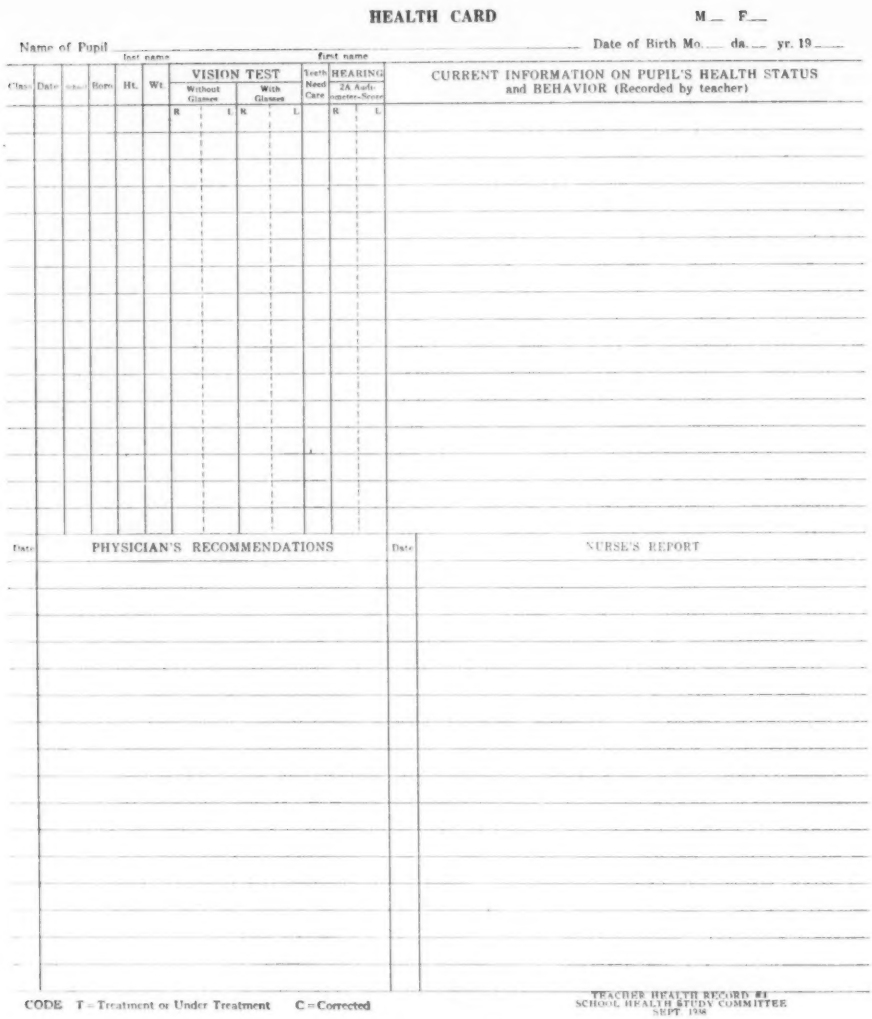
THE HEALTH RECORD

It is the health record which is the basic tool that coördinates the work of all those interested in the child. It furnishes the written evidence of their mutual interest in the child and their joint efforts to help him achieve his health goals. The information entered on the record gives subsequent teachers a better understanding of the child's past and present health status. It is a health map which serves as a guide to the teacher, to direct her in meeting the health needs of each child in her class.

The Health Card is an individual, cumulative record and is passed on from grade to grade and from school to school as are the Medical and Academic records. The face of the record has space for notations for each term showing the grade, height, weight, audiometer score, visual-acuity scores obtained by teachers, dental needs as ascertained by private or clinic dentists, and any current information the teacher has regarding the child's health status. All of these data are written on the Health Card by the teacher.

The lower half of the card is divided into two parts. In one part the physician, in lay language, tells the teacher —not what his findings are but what his *recommendations are*. These recommendations include not only the medical guidance given the mother but also the specific part the teacher is to play. Thus they may contain such directions as: Observe for symptoms of fatigue; report absences due to colds to nurse; release child from all possible tensions in classroom.

In the other part of the card, the nurse records for the teacher the facts she ascertains from conferences with the parent and from information received



HEALTH CARD M__ F__

Name of Pupil _____ Date of Birth Mo.__ da.__ yr. 19__

last name first name

Class	Date	Age	Born	Ht.	Wt.	VISION TEST Without Glasses R	L	With Glasses R	L	Teeth Need Care	HEARING 2A Audiometer-Score R	L	CURRENT INFORMATION ON PUPIL'S HEALTH STATUS and BEHAVIOR (Recorded by teacher)

Date	PHYSICIAN'S RECOMMENDATIONS	Date	NURSE'S REPORT

CODE T = Treatment or Under Treatment C = Corrected

TEACHER HEALTH RECORD #1
SCHOOL HEALTH STUDY COMMITTEE
SEPT. 1938

Face of record

from private physicians, clinics, and social agencies.

On the back of the record are listed specific observations which experimental work has shown to be significant in detecting deviations from normal health conditions. There are sufficient columns for each teacher to check her findings during the eighteen terms the child is in school.

THE TEACHER'S CONTRIBUTION

The most valuable contribution the teacher can make to the health service aspects of the school health program is through her recognition and reporting of the symptoms she observes and believes are deviations from normal behavior. In the Astoria program, the importance of teacher participation of this type has been emphasized not only with teachers but also with nurses and physicians. The teacher thus has the responsibility for being the first line of attack on health problems. Not being qualified to make diagnoses, she is of course not charged with this responsibility. She occupies, however, a

TEACHER'S OBSERVATIONS	Class →																
EYES	Styes or Crusted lids																
	Inflamed eyes																
	Crossed eyes																
	Frequent headaches																
	Squints at book or blackboard																
EARS	Discharge from ears																
	Earaches																
	Fails to hear questions																
NOSE AND THROAT	Persistent mouth breathing																
	Frequent sore throat																
	Recurrent colds																
GENERAL CONDITION AND APPEARANCE	Very thin																
	Very fat																
	Does not appear well																
	Tires easily																
	Poor muscle coordination																
	Bad posture																
BEHAVIOR	Emotional disturbances																
	Speech defect																
	Twitching movements																
	Nervous																
	Unduly restless																
	Shy																
	Bites nails																
	Uses lavatory frequently																
HEALTH HABITS	Poor sleep habits																
	Poor food habits																
ABSENCES FOR ILLNESS	Write Causes Below Enter No. of days absent in "class" column																
	Colds																
	Stomach or intestinal upset																
	Others (specify)																

Back of record

unique position, since she is with the child every school day. Not so the physician and nurse. The teacher, and she only among the school staff, is in a position to observe behavior symptoms and changes from day to day. The Health Card furnishes her a medium for recording these observations.

TECHNIQUES OF USE

The Health Card with its notations is a tool which in at least two ways has proved itself effective: first as a basis for the class conference between teacher and nurse, and second as a source of supplementary data to be used by the physician in connection with the physical findings of his medical examination.

In the class conference the nurse, having before her the teacher's findings, is able to explain to the teacher more fully the importance and significance of her observations and to determine whether the child is to be selected for an examination by the physician. It is in the conference that an exchange of

information takes place. With both medical and health records before them, they can discuss the needs of each child in the room—those who are so-called "normal" children and those with health problems.

SELECTING CHILDREN

When medical and nursing services are limited, it is important that a most careful selection be made of children referred for medical attention. Such a selection demands good judgment on the part of the nurse. She has the responsibility for spreading medical service throughout the school so that no child needing attention is overlooked and also so that children are not referred to the physician needlessly—thus depriving others needing care. Selecting these children is therefore a challenge, and in meeting the challenge the conference between teacher and nurse develops into a thoughtful weighing of facts, findings, and values leading to selections that establish the responsibilities to be assumed by the teacher, the nurse, and the principal.

It is important in the school health service that all participants know what each can and does contribute to the whole program. The class conference promotes this understanding. In the discussion of each child the nurse will determine from her own knowledge of the child—based on information obtained from the parent, from previous examinations, if any, and from information given by the teacher—whether the child:

1. Is under adequate medical supervision.
2. Should be observed further by the teacher for more definite history.
3. Should be referred to the school physician for an opinion.
4. Should be referred to the school physician for a complete medical examination with the parent present.

The time required for a conference of this type will depend largely upon the number of health problems in the class but to an even greater extent on how well the teacher is equipped for her part in the program. Courses for teachers in health education too often fail to give the desired results. Theoretical lectures do not usually meet practical problems. Perhaps the best way to meet this need of teachers, for the present at least, may be found in the instruction the nurse can give the teacher. The class conference is well suited for this purpose and is an opportune time for it. The nurse can judge from the types of observations noted by the teacher whether she needs special assistance. Teachers welcome this type of help. They are eager to learn from the nurse about conditions affecting the child—such as past illnesses and home conditions—and to discuss with her the child's peculiarities in school and his reactions generally to work and play.

BEHAVIOR SYMPTOMS

Teachers need to know that the following symptoms may have meaning in connection with the health of a child:

1. Facial expression indicating pain, worry, tension, fear, comprehension or lack of it.
2. Appearance of face—pale or flushed.
3. Strabismus, styes, inflamed eyes, headaches, frowning, holding the book close.
4. Mouth breathing, frequent colds, sore throat, hoarseness.
5. Discharging ear, wearing cotton in ear, earaches.
6. Turning head to one side when listening, often failing to hear remarks.
7. Thinness, tired appearance, tiring easily, poor posture, losing or failing to gain weight, circles or puffiness under eyes.
8. Pitch of voice—high, low, mumbling, or stuttering.
9. Emotional, social, and physical traits such as shyness, backwardness, crying easily, nervousness, restlessness, day-dreaming, attracting attention, temper-tantrums, sulkiness, quarreling, asking to leave the room frequently, complaining of a variety of ailments, biting nails or lips, facial spasms, jerking movements, inability to write in a straight line or to concentrate for any length of time, lack of muscular coördination.

Teacher-nurse coöperation does not end with the class conference or with the selecting of children needing medical care. At the time of the medical examination the nurse presents the health record to the physician with a complete picture of the child's condition as reported by the teacher and any additional information the nurse has regarding the child's health, home conditions, or other significant data. The physician makes his recommendations and plans with the nurse and parent for medical attention or supervision. His recommendations to the teacher are entered on the health record, which is returned to her. The interest of the teacher in the health program is augmented and maintained when the physician and nurse keep her informed of what is being done for the child.

The coöperation of the teacher and nurse does not limit itself to the four walls of the school. The nurse in her home visits often learns of conditions which explain much of the child's behavior in school and she imparts this information to the teacher. The nurse is in a position also to explain to the parent how the teacher is endeavoring to promote the child's well-being, and the necessity for the parent's coöperation with the teacher.

The nurse, the teacher, and the physician are co-workers in the school health service. They need good tools and they need to use them intelligently. Individual effort is often wasted effort. The only practical formula for improving school health work lies in joint action—intelligent and willing coöperation by all who work with the child—and through more efficient tools and improved techniques and relationships.

COLLEGE NURSES EXCHANGE IDEAS

MORE THAN FORTY college nurses met for the first time to exchange ideas and problems at a breakfast session on May 6, at the annual meeting of the North Central Section of the American Student Health Association in River Falls, Wisconsin. In addition to the nurses attending, there were college physicians, deans, faculty members, and others present.

Mellie Palmer, instructor of the course in public health nursing at the University of Minnesota, presided and introduced the discussion. She reviewed the history of school health service from its early limited scope of communicable disease control to its broader objectives of today. The subsequent discussion revolved around questions sent in by the nurses in advance, with emphasis on the problems of the small college. The descriptions of college health programs given by nurses from various institutions showed a wide variation in personnel, equipment, budget, standards, and activities.

Certain aims and activities were found, however, to be common to all. The care of sick students; health examinations and follow-up; health education through classes; coördination of the service by means of faculty health committees—these threads appeared through the various programs. It was emphasized that if the health service is of real worth to the students they will not object to paying a health fee.

An exhibit of records and report forms and other working tools, which the nurses brought for display in order to exchange ideas, proved to be of interest and value.

RAIDIE POOLE, R.N.
State Teachers College
Superior, Wisconsin

An Educational Health Examination

By MARION E. STEVENS, R.N.

A school nurse analyzes some of the educational aspects of the school health examination, to see how it can best accomplish its most important objective

SCHOOL NURSES will agree that the school health examination occupies an important place in the health education program of the school. It consumes a great amount of the nurse's time and touches the lives of practically all students during their school career. We need, therefore, to examine closely the service being offered in order to determine just what its contribution is to a program of real education. As yet we have rather unsatisfactory methods of definitely appraising our work, but we do know that health information becomes vital only when people incorporate it into actual living; when they literally remake their lives with their newer, better knowledge. It is questionable whether many of the examinations made arouse any great desire on the part of pupil, parent, or teacher to undertake such changes in the physical well-being of the child. Apparently we are failing to develop all the educational aspects which are inherent in the examination.

STRESS THE GOOD AS WELL AS THE BAD

The examination itself has health education as its major objective. It should therefore provide an opportunity for the child to accustom himself to the routine of an examination. It should develop favorable attitudes toward health matters in general, in addition to definite knowledge about himself. It should be an appraisal of the status of the whole child rather than limited to a discussion of only wrong features. Often there are many "right" things in the development of the child; by stressing only the wrong ones, a full opportunity for education is lost. Perhaps the nurse and teacher have carefully prepared a class for the examination. The time arrives, and the child comes to the health office eager and expectant. The physician is hurried and indifferent and fails to rise to the occasion. All the good points of this eager, expectant child are taken for granted and the child is humiliated by the physician's emphasis on his defects.

Mary, a kindergarten child, came for her first school examination. She was interested, and proud of her sense of well-being. The examination was desultory and superficial and she was greeted with the physician's comment, "You have bad teeth." She had merely a small cavity in a deciduous tooth—in fact, the only tooth in poor condition in an otherwise healthy and clean mouth. The nurse could see her wilt under the feeling of inferiority it gave her. Finally she could bear it no longer, and regaining some of her former pride held out her hands to the nurse to show beautifully kept nails which she had groomed as part of her preparation for the examination.

Some recognition of this child's splendid personal appearance by the doctor would have made her ready to accept any recommendation on the need for dental care. As it was, nothing but her defect was stressed, and psychologically the child was no longer eager for further health examinations.

Since the examination is limited in scope at best, a failure to develop these favorable attitudes that are so necessary and important to the child's coöperation

seems tragic. The examination does not aim at complete diagnosis nor does it provide advice as to treatment, but it should at all times make a serious effort to establish suitable attitudes toward health in its entirety. The nature of the examination renders it especially valuable for accomplishing this objective.

Each school system will have a different way of conducting the health examination. There may be wide variations in the responsibility assumed by different staff members for parts of the examination. Yet the general guiding principles are much the same. Few schools have adequate personnel to conduct satisfactory examinations for all pupils every year, so many of them conduct thorough examinations about every three years, giving first consideration to all new children. The school has a great responsibility to set up the health examination as a type of educative experience of the right kind, for certainly a poor examination invalidates the whole program. Increasingly, schools consider that fewer and better examinations are definitely more valuable than numerous rapid ones.

TEACHER SHOULD PARTICIPATE

Oftentimes the teacher is left out of the health examination. This is unfortunate, for she has a valuable contribution to make. No one in the school program has a better opportunity to develop close relationships with the children. The nurse and doctor find their work made easy when the teacher has assisted in the preparation of the children. As the teachers become more aware of the possible value of the examination to the child and the contribution it can make to his better adjustment, they are more eager and alert in paving the way for him to catch the spirit of what a real examination means. Sad, indeed, is the examination where the doctor and nurse fail to live up to the expectation aroused by an interested teacher. The teacher needs the findings to help the child in the most intelligent manner, and her knowledge of existing defects and special problems will greatly influence their correction. For instance, she can help the child and parent to see the relationship between an existing vision defect and a failure in reading ability; the relation of fatigue to lack of sleep due to late listening to the radio; and many other situations. The data of the physical findings can help to vitalize all health instruction in the classroom.

It is not always possible for the teacher to be present at the examination itself nor is it always desirable. Privacy should be maintained for the child, and too formidable an array of spectators makes him uncomfortable and interferes with his concentration on the examination. When the parent is unable to be present, the teacher's presence is very helpful; but whether or not she is present, the findings should be in her hands. When she is present, she is able to enlarge her own knowledge of signs of health and deviations from normal. Her understanding of the examination, used in actual classroom situations, provides her with live teaching material. Teachers have been known to make a unit on dental instruction come alive after being present at a dental survey of their class where they could see the ravages of dental caries. Once a teacher is convinced of the value of health service and instruction, based on her knowledge of the need, she will find time in her already busy day for an excellent program of instruction.

All of the procedures of the examination move along better channels of usefulness when adequate preparation is made in advance. A great deal of the responsibility for this preparation belongs to the nurse. She will secure as much help as she can from the teacher. If the children know when they are to have their examination they will be far more interested. If they know what

is to be the type of examination they will not expect it to be the type of service which the family doctor offers them.

WIN THE PARENTS' SUPPORT

In some schools the written consent of the parents is required for the examination. An examination against the parents' will often means that all objectives of parental education are lost. The full consent of the parents and their presence at the examination, especially of the younger children, is the initial step to a successful examination. It then becomes important for the nurse to have laid the groundwork in previously preparing the child so that he is receptive and willing for the doctor to give the type of examination which the parent can understand and respect. Great enthusiasm for the health examination cannot be expected from busy parents unless its value in furthering their understanding of the child is sufficient to make it worth their while. Certainly if no time is given to discussion, and if the parent senses a feeling of hurry and unwillingness to answer justified questions well within the area of the examination—the nurse and physician may feel the examination has been worse than nothing as far as the parent, the child, and the school are concerned.

If the doctor finds some gross defect such as a marked curvature of the spine, or an enlarged thyroid, the parent will be more impressed with the findings if the examination has been careful and skillful. Corrections are more apt to be made promptly when the parents are present and are convinced of the need for a more thorough check-up by their family physician. Sometimes the situation may provide the stimulus to get something done about conditions of which the parents had previous knowledge but for which they needed the extra bolstering provided by the school examination. At other times it reveals a condition of which the parents were completely ignorant. Again they were aware of the defect but did not know that corrective care was possible. All through the examination, as various problems of physical fitness and emotional control are revealed, the nurse and doctor should not lose sight of the need to secure the understanding of the parent. They can ill afford to neglect the courteous handling of the situation for it is impossible to go very far toward correction unless the wholehearted support of the parent and the child is secured. A hurried examination is therefore not feasible and perhaps does more harm than good, for it accomplishes none of the important objectives of the examination.

CHILD'S ATTITUDE IS IMPORTANT

It is very important that the examination be a pleasant experience for the child. All of the situation should be controlled with this in mind. Sometimes an examination is conducted in which no direct statement or question is addressed to the child. He is just treated as a bit of flesh to be rapidly undressed, made to open its mouth, thumped a bit on the chest, and then told to dress and given a slip of paper. This is deplorable and the child is bewildered by such treatment. Attitudes are achieved; but not attitudes that will make him wish to return to the doctor again for further humiliation. In an educationally effective examination the child receives courteous treatment. He is the center of the examination. Some explanation is given, in terms of his understanding, of his good points. Suggestions are given where further help is needed. Perhaps it is a matter of the child having more sleep, more milk, or codliver oil. Even when the taste of codliver oil is repugnant to a child, he will usually take it if he is convinced, through proper teaching, of its importance to his growth and development.

It is most important for him to leave the examination with some assurance in regard to how he can meet his problem. Unless some definite attempt is made by the doctor and nurse to relieve anxiety, many children will worry unnecessarily about unsolved problems and unexplained suggestions.

If a detailed discussion is desirable between doctor, nurse, and parent, in cases where special problems are involved, it should be postponed until the child has gone back to his class. If he listens to a conversation regarding certain problems, he may suffer an emotional reaction which will cause personality difficulties. This does not mean that he should not learn to face his handicaps. But he will certainly not be helped by listening to mother's excited conversation on why he will not eat his carrots, how he refuses to obey his parents, and how he stays up beyond bedtime. A quiet talk later between the teacher or nurse and the child may result in a much more helpful treatment of the whole problem.

The nurse and doctor should be deeply sensitive to the learning situation which they are building up for the children. If the children are indifferent, if they dislike the idea and see no value in the experience, it would be well for the professional staff to examine critically the educational techniques they are employing in the examination. Every experience is a learning experience but it may not be the right kind of learning. Surely one cannot expect the coöperation of the children in making use of the results if they do not understand these results.

If the school physician does not make the findings of the examination clear to the child, the nurse should interpret them. In order to be most effective, this must be done at the time of the examination. True, there will not be a great deal of time for discussion. But sufficient time is possible to clear up certain phases of the situation which may be puzzling to the child.

The findings from school examinations provide the principal with illuminating data on the physical needs and problems of the community from which his school population comes. This information can be of aid to him in securing an environment in which conservation of all the physical resources of his pupils is paramount. The findings will also help him interpret to the parents the child's scholastic progress and adaptation to all elements in the school situation.

If the school health examination helps prevent and correct unnecessary handicaps; if it develops the desire on the child's part to seek medical supervision for his growth and development now and in later life; if it helps him remake his emotional and nutritional habits of living; if it helps parents to a greater appreciation of what actually constitute fine, strong bodies and of the ungained heights accessible to their children through improved habits; if it assists other members of the school to carry on a more effective piece of education—then, indeed, all of the time which the nurse and doctor may devote to the examination is justified in terms of the fuller life they can make possible for school children.

Conducting A Child Health Conference

By AMOS CHRISTIE, M.D.

A physician with broad experience in child health conferences presents his concept of a conference whose primary objective is parental education

THE PUBLIC HEALTH NURSE is the keystone of any public health program; upon her ability, energy, tact, and judgment will rest the success or failure of all the objectives of the child health conference. These objectives will be reviewed here, together with some practical points in the nursing administration of such conferences from the standpoint of the physician. Particular emphasis will be placed on the rural conference.

OBJECTIVES OF THE CONFERENCE

The primary objective of the child health conference is parental education. Since 1893 when the first milk station was established in New York City* there has been a constant growth in the child health movement. The response of the infant mortality rate to this movement is a matter of history and it is gratifying to recall the part played by the child health conference in this tremendous saving of life. The conferences establish for parents an educational center where they may be guided in the establishment of physical well-being and desirable emotional habits in the child, and a more sound parent-child relationship. Here early deviations from normal growth and development, mental and physical, may be observed and the parent advised as to the need for correction. This is one of the goals of preventive medicine.

Besides the parental education features of the child health conference, at least one other objective is of importance to the nursing profession. The conference provides an educational experience for the nurse, which prepares her to do a better teaching job. It gives her an opportunity to evaluate her teaching methods. The correlation in the conference of the various parts of her work, such as nutrition, mental hygiene, school health, dental hygiene, and sex education should be among her aims.

Obviously the child health conference is not the only place where educational work may be done. Mass public health measures are necessary, but they require a constant definition of purpose and attention to their limitations. They are unlikely ever to be a substitute for the individualized health supervision accomplished by the physician in private practice or in the conference or clinic.

The suggestions and opinions in this article are based on eight years' experience in conducting urban well baby conferences in a teaching hospital, and recently two months of observing and conducting conferences in a rural part of the West.*

ADMINISTERING THE CONFERENCE

Ideally at least two nurses are in attendance at the child health conference in addition to the conducting physi-

*McCleary, G. F. The Early History of the Infant Welfare Movement. H. K. Lewis and Company, Ltd., London, 1933.

*See "Refresher Courses in Clinical Pediatrics—An Experience in Post-Graduate Education," by Amos Christie. *The Journal of the American Medical Association,* April 29, 1939. pp. 1660-1664.

cian. If the nurse is to fulfill the primary educational objective of the conference her time can be better spent than trying to make her records perfect in appearance—which would put her in the class of a clerical assistant, not a teacher. This does not preclude the possibilities which records possess as living instruments for teaching.

The nurse's time wherever possible should be saved for professional activities which no one else is qualified to perform. Her time can be utilized better for educational purposes than in taking temperatures, and weighing and measuring babies, except in situations where these procedures are utilized for specific educational purposes, such as teaching the mother to observe certain features of normal growth and development. The nurse may teach lay volunteer assistants to carry out these procedures. The use of volunteer service extends the educational value of the conference and seems sound from an administrative standpoint.

Number of children attending

The attendance at any conference is dependent to a large degree on the effectiveness of the nurse's contacts with the parents. Too much emphasis, however, should not be placed on *quantity* in evaluating the work of the nurse; *quality* is of more importance and this cannot be obtained when the conference is too large. An appointment system works well in the child health conference, and the nurse is responsible for seeing that it runs smoothly. Each conference is planned so that there will be no unnecessary duplication. The appointment system limits the attendance to the number that can be given satisfactory service, and it insures that in a limited time each mother shall get her allotted period.

Too many appointments should be avoided. The physician will fulfill his part of the educational work better if he does not have too many children to examine and if the session is not too long. The writer believes that two hours should be the maximum period for the physician doing child health conference work, and that an average period of at least six minutes should be allowed for each examination—including recording and the talk with the parent. If the doctor is spending less time and doing superficial work, readjustments in the procedure should be made.

The frequency of attendance is a matter entirely dependent on local conditions. A standard often set is that every well baby should be seen each month until he is nine months of age and every three months thereafter until two years of age. From two to six years of age it is usually considered sufficient for well children to have examinations every six months.*

In more prosperous communities there will be a large percentage of small infants under the care of private physicians. In certain communities it will be impossible for mothers to bring small infants to conferences without also bringing two or even three preschool children, and some conferences meet this situation by admitting both infants and preschool children. However, in such a conference the nurse should strive for an attendance which is not too heavy with the older preschool group to the neglect of the infants. It is desirable that 60 to 70 percent of the attendance in this type of conference should be infants and preschool children under two years of age, if possible.

Occasionally the attendance will take a radical drop. If this should happen for three consecutive conferences, a

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*Editor's Note: A recent letter of inquiry sent by the National Organization for Public Health Nursing to several agencies in various parts of the country which are doing intensive child health work showed a wide variation in the standard for frequency of attendance at the conferences, with a trend toward attendance based on the needs of the individual child rather than a rigid schedule.

study of the situation may reveal an obvious reason—inclement weather for example. Again, the reason may lie in the personnel. While it is true that a great deal of the success of any conference depends on the nurse, all the responsibility is not hers. A disinterested or poorly informed physician in charge may be the one who antagonizes the mothers and who is not giving them what they want and need, in spite of a capable nurse. Before discontinuing poorly attended conferences, changes in the conducting personnel might be considered.

Eligibility for attendance

Eligibility for attendance at the child health conference should be established on the basis of the general philosophy of the community where it is conducted. The pressure of public opinion and the viewpoint of organized leadership, such as the medical societies and lay groups interested in child welfare, must be considered. It is of the greatest importance that the sanction of the medical society should be obtained on this point.

It is not sufficient merely to establish child health conferences and provide personnel for them. Administering authorities should recognize a fundamental principle underlying this service, which is the establishment and preservation of the personal relationship between physician, child, and parent. It would follow then that it is wise to exclude from the conference not only those children already under the care of a private physician but also those whose family income is sufficient to provide what we know to be adequate health supervision.

However, the writer is strong in the personal opinion that the child health conference in rural areas where the medical service is limited should be open to all regardless of socio-economic rating, with the exception of infants already under continuous supervision by private physicians. If it is known to all physicians that the conference is educational and preventive in nature, there is no reason why they should object to another physician examining their patient during the course of the conference. When the private physician realizes that any defect found in such a health examination will be referred to him for correction, he will usually welcome the consultation service. The health supervision of a child should of course have continuity, and it is important that the information in the possession of the private physician and the conference be available to both, when both are interested in a child.

Location, equipment, and time

These factors will vary because of local conditions and will be discussed here only briefly.

The location of the conference will depend on local needs and funds available. The greatest need is in the very rural communities. Studies have shown that but 37 percent of preschool children in these areas have ever had a single health examination, while at least 51 percent of urban children have had such advantages.*

The conference may be held in any chapel, church, recreation hall, school, courthouse, or old theatre where at least three rooms are available if possible—a reception room, a room for the medical examination, and a room for the nursing conference. Running water is desirable but not absolutely necessary. A basin with soap and water can be used by the doctor to wash his hands after each examination. Alcohol sponges are required for the cleansing of his stethoscope. In general the nurse is responsible for the equipment and procedure which are designed to prevent the spread of communicable disease at the conference.

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*White House Conference on Child Health and Protection. Health Protection for the Preschool Child. The Century Company, New York, 1931, p. 15.

The time of the conference will depend on the convenience of the conducting doctor and the hour that local mothers can attend. If the physician is paid for this time he will be more apt to be regular and prompt.

Occasionally a medical emergency will arise, in which case the physician will secure another physician to take his place. Plans for an alternate whom the nurse can call in case of illness or other unavoidable circumstance is a satisfactory arrangement.

THE NURSING SERVICE

The educational success of the conference depends largely upon the public health nurse. Specifically, she is responsible for the following functions:

1. *The training and supervision of volunteer assistants*

It is obviously impossible for one or two nurses to be responsible for the many duties in a conference. Therefore, the nurse should instruct and supervise a group of volunteers, who can do much of the nonprofessional work. Volunteer workers may be used as hostesses; they may secure and convey records, keep the appointment system running smoothly, and prepare conference rooms—particularly when the nurse must travel a long distance to reach the conference; they may take temperatures and weigh and measure children.

The administrative principle of local participation is so essential in any public health program that volunteer help should be utilized. The public health nurse who would "rather do it myself" when she sees a baby being handled with less deftness by a new volunteer assistant is not a good teacher. The record forms are usually nontechnical and there is no reason why the volunteer cannot start the history by filling out the routine questions at least to the point of personal history.

2. *Record-keeping*

A system of record-taking should be carried out which will include all the social, medical, and nursing information the nurse has accumulated in her home visits as well as that obtained in the conference—all of which should be brought to the physician's attention. The physician's examination and his educational interview with the parent are the culminating points of the conference, and he will need to have these facts.

One possible way to save time at the conference is to have the record form made out in advance for each new child. The nurse can sometimes do this on a previous home visit, when she is giving postpartum nursing care in a home delivery, or when she is making the first contact after notification of the birth. In some agencies she may visit the home to deliver the birth certificate. (The nurse can be of inestimable value to the mother in the proper registration of the baby's birth and should consider it her responsibility, especially in rural areas.)

3. *Parent-education*

The public health nurse should be responsible for the instruction of mothers at the conference. This may be done by informal interviews and demonstrations or by planned group discussion in the waiting room during the conference. Such topics as formula-making, foods and their preparation, the bath, clothes, play materials, and habit formation may be discussed—depending on the mother's needs.

The conducting doctor, being hurried, is frequently somewhat indefinite or his instructions may be incomplete. His suggestions and program should be mapped out for the mother before she leaves the conference so that she may not leave feeling confused. She often does not obtain the full benefit of the contact with the physician because she does not want to ask what may seem foolish questions. Consequently, an excellent method of making the conference an educational success is to set up a nursing conference room outside the doctor's consulting

room. Here the nurse, nutritionist, or psychologist may sit with posters, government bulletins, and demonstration materials at hand. The mother is now relaxed; her infant is usually quiet, and she will ask questions more freely than in the presence of the doctor. Such details as how to scrape beef, how to cook the cereal, and how to understand the developing personality of the child will come with more spontaneity. The final remark is frequently: "Do you have any more questions?" Every effort is made by the nurse to give information in such a way as to strengthen the doctor-patient relationship.

The preparation of the public health nurse is such that she can be of great educational value to the mother in the home, and the child health conference is not a substitute for the home visit. Every visit in the home should be a teaching interview. The initial visit may be during the antepartum or postpartum period; upon delivery of the birth certificate; or at the request of the doctor. The nurse should call at the home within a week after a well baby or preschool child has been admitted to the conference if she has not made a previous visit and seen the child in his home environment. In the case of very young infants it would be preferable to make a visit within 24 to 48 hours, but this is often not practical in rural areas. Home visits in general will depend on the individual need. A child with feeding problems or a premature infant may need many more than a single home visit, where the normally developing breast-fed baby may not need one.

A home visit offers an excellent opportunity for the demonstration of formula-making, if that is needed, or to emphasize the reasons for giving codliver oil and orange juice and the technique of giving them. The need and time for immunization may be introduced. The nurse may talk over the doctor's orders as to the care of the skin, the retraction of the foreskin for phimosis, or diaper hygiene. She may point out the value of proper laundering and boiling of diapers to prevent rashes. In any case she will start her teaching with the needs and problems which the mother herself recognizes.

There is need for administrative and teaching ability in rural nursing. Distances are great and frequent calls cannot be made. It is therefore most necessary to use the teaching time to the best advantage, to demonstrate wherever possible, and in many cases to leave with the mother detailed, written instructions.

SERVICES TO THE PHYSICIAN

The nurse is responsible for the smooth running of the conference, for making appointments for return visits, and for acquainting the conducting physician with the social and medical facts she has learned in her home visits or during previous contacts with the mother.

An excellent method of informing the physician about pertinent facts is to record these on the infant's chart. Such remarks as "child wetting bed," "cannot afford sufficient milk," or "child refuses codliver oil," for example, will give him an insight into the psychological or social situation and a lead for him to follow up in regard to habit formation, which would be unobtainable otherwise.

If immunizations are performed at the conference, the nurse will assume responsibility for obtaining permission from parents. She will make ready the needed materials, prepare the areas for inoculation, and see that they are recorded. Any skin rash or upper respiratory infection, or a rectal temperature above 100° Fahrenheit is a contraindication for any immunization procedure. Complicating rashes or reactions may endanger the entire immunization program.

The assisting nurse will see that the child enters the examining room undressed. Children under two years of age should be completely undressed.

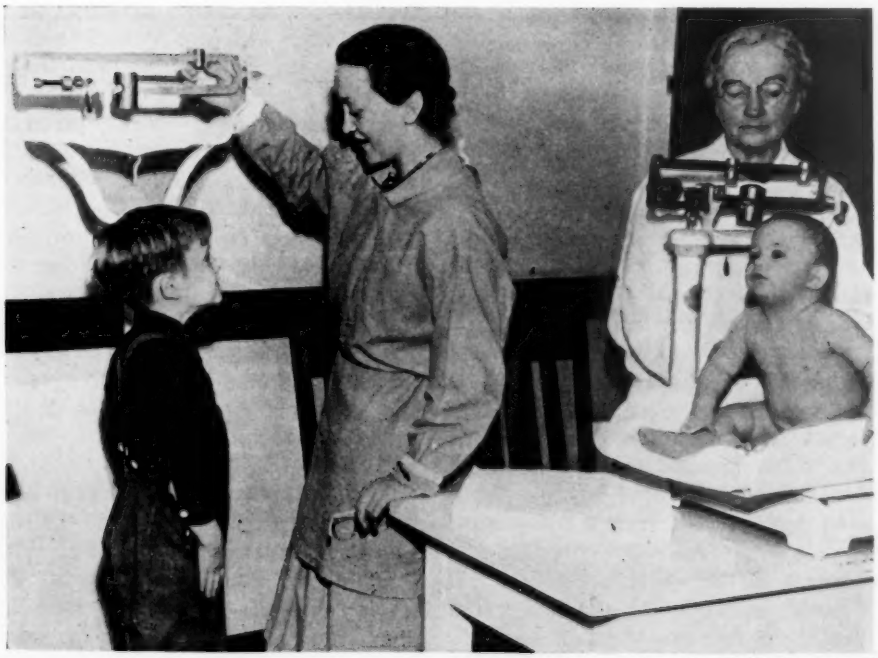
Panties or bloomers may be used for the older children. The nurse will also assist the physician in securing the coöperation of the child. This will facilitate a better examination.

SUMMARY

The objectives and procedures of the child health conference have been reviewed from the standpoint of the conducting physician and the public health nurse. The most effective methods of carrying on this program of parental education are the constant concern of the physician, the nurse, and the volunteer assistants. This program should assure a saner parent-child relationship in the direction of sound physical and mental health for future citizens. In the words of Dr. Milton J. Rosenau: "Preventive medicine dreams of these things, not with the hope that we, individually may participate in them, but with the joy that we may aid in their coming to those who shall live after us. When young men have vision, the dreams of old men come true."*

*McCormack, Arthur T. "Public Health the Basic Factor of Social Security." *American Journal of Public Health*, November 1937, p. 1080

NOTE: The writer wishes to acknowledge the many helpful suggestions of Miss M. Olwen Davies, instructor in public health nursing, University of California Hospital, in the preparation of this article.



Courtesy of Los Angeles City Health Department

Watching them grow

Making Our Democracy Work

MAINTAINING our democracy was the theme that ran through the whole National Conference of Social Work at its annual meeting in Buffalo, New York, on June 16-24, 1939. This was emphasized in the slogan selected by the Community Chests and Councils for their 1940 mobilization campaign, "Good Americans Make Good Neighbors." This was the title of an address presented by Dorothy Thompson before the Washington, D.C., Community Chest. She said:

> This giving of something more than is demanded, this contribution of the individual to his society, over and above what can be compelled, is of the very essence of democracy. For democracy is founded not on force, but on the very thing that impels this community chest movement—the belief that a society and a government can be founded in voluntary coöperation and rooted in mutual good will.

In Paul Kellogg's presidential address he sketched the history of the development of the Midwest, in order to show what needs to be recaptured in our democracy for developing better citizenship.

The maintaining of what we stand for was brought out in all the talks, and in the final address by Dr. Alice G. Masaryk, she showed us what faith and hope in a democracy could be.

Some six thousand delegates attended the meetings and everyone agreed that it was one of the most stimulating conferences they had attended in a long time. The discussion seemed to be full of meat, and the social workers themselves seemed less harassed and pressed by problems. One had the feeling that everyone felt he was doing the best job he could; and there was the feeling that even in the face of opposition and difficulties some of our ideals might be achieved, with patience and courageous thinking and planning.

Greater emphasis was put on the development of councils in the community chests and council programs, and throughout all this social planning the need was brought out for greater use and greater development of the laymen. Edward L. Ryerson, Jr., a layman of Chicago, emphasized again and again that the laymen today should be brought more into the picture, not only as volunteers but as participants in social planning.

NATIONAL HEALTH PROGRAM

The national health program was presented in a paper by Dr. Thomas Parran. "Our first task," said Dr. Parran, is to "minimize the risk of illness, to reduce its amount. This is more important than spreading costs. Yet I believe that group payment of the cost of medical care, through taxation or insurance or both, is an important factor in any complete national health program."

Other speakers on health problems included Josephine Roche, Helen Hall, Michael M. Davis, Clifford E. Waller, and Martha M. Eliot. Considerable time was spent on the problem of medical care for the indigent and for the chronically ill. On the last day of the conference, Dr. Kingsley Roberts, Dr. John P. Peters, and Dr. R. G. Leland presented summaries of group medical care plans, discussing straight health insurance, prepayment service plans, and coöperatives.

As a whole the health meetings have never been so well attended and the "corridor conferences" grew heated at times over the pros and cons of the pending Wagner health bill (S-1620). It is always refreshing to hear the social worker's approach to health problems, freed as it is from the professional inhibitions of doctors and nurses. The report of the health activities as summarized

in the *Survey Midmonthly* for July is worth reading. Helen Hall said:

> The social workers of America do not need the National Health Survey to tell them of medical needs in the United States. Each one of us has the story direct from people among whom we have worked. We would not all stress the same lack, for our areas of concern cover country people and people in our crowded cities; people in coal mining areas and sparsely settled farm districts; southern mountain districts and Negro workers in city and country. . . . Social workers know everyday people everywhere, know them at first hand and know that their medical needs are not yet adequately met. And for us no voices insisting that all is well can drown the voices of the people we know and represent.

The medical social workers were also present in numbers and presented thoughtful material on intramural and extramural programs.

Publicity was stressed throughout many of the sessions and definite suggestions were made for publicity programs. At the final meeting of the American Public Welfare Association, two speakers developed the subject "Public Opinion and Public Welfare." Ernest K. Lindley, columnist and Washington representative of *Newsweek Magazine*, examined many of the current criticisms of public welfare and social workers. He pointed out the need for social workers to consider the economic problems, as well as the social problems. He called attention to the feeling of many laymen that social workers think only in terms of spending money and said they give the impression that their program is going to have to go on forever. His comment was that "they should do more to give the impression that they are trying to work themselves out of their jobs."

Some interesting facts were brought out by William A. Lydgate, editorial director of the American Institute of Public Opinion. He summarized the public's belief as follows:

> The public believes, in the first place, that aid to the unemployed is a responsibility of government. This, I suppose, is a relatively new concept; certainly the present scope of government aid to the jobless was not foreseen ten years ago. The principle of government responsibility for the unemployed needy seems to have become a definite part of the mores and social philosophy of our times, for today more than 70 percent of the voters think government should shoulder this responsibility.

A dinner meeting for laymen had for one of its speakers Sidney Hollander, member of the Board of Maryland State Aid and Charities, who is active in other boards and social welfare work. In a talk, very humorous, extremely critical, and very inspirational, Mr. Hollander challenged the laymen in regard to their part in making our democracy work. He said:

> Democracy has no appeal for discouraged rebellious youth—for workless and hungry men. If we continue to deny Americans food to sustain them, clothing to cover them, homes to shelter them, we are implanting resentments that will not quickly be forgotten.
>
> America must have a program of welfare that faces realities, not one that ignores them; a program that recognizes the fact that we can and must provide work for those who can labor and support for those who cannot; that people must eat whether we list them as "employables" or "unemployables"; that they must have clothes whether they are married or single; that they must have a place of shelter whether they are black or white; that they are eligible for sickness and death even though they may be ineligible for relief.
>
> Action may be needed on many fronts. Pressure must be brought on city and state welfare departments to insure adequate budgets and competent direction, and unceasing vigilance to protect the public programs, from political intrusion or control.

The president of the Conference for the ensuing year is Grace L. Coyle, Western Reserve University, Cleveland, Ohio, and the next conference will be held in Grand Rapids, Michigan, May 26-June 1, 1940.

Supervision of the Nurse in the School

By MARY ELLA CHAYER, R.N.

An authority on school health discusses the value of nursing supervision for the nurse in the schools, and outlines some of the administrative problems which arise

SUPERVISION is the means employed by organizations for the improvement of their service. Early methods of supervision by means of inspection and espionage proved so ineffectual that they are gradually being superseded by more democratic means. The improvement of service resulting from supervision is only superficial unless it is accompanied by the greatest possible development of the individual. Supervision thus conceived implies a knowledge of the self and a knowledge of the job. The purpose of supervision is to help the staff personnel know themselves and what they need in order to render the most efficient service; and to give them assistance in acquiring the knowledge and the techniques necessary for self-improvement. Analysis of the individual and of the situation must therefore be continuous and must be participated in by every member of the personnel, if supervision is to result in improvement of the individual in the quality of his performance.

THE SCHOOL'S PLAN OF SUPERVISION

The supervision of the nurse in the school presents a problem in many respects different from that of supervision of the nurse in other situations. The school is not primarily a health organization. Its essential purpose is general education and its administration and program are set up with that end in view. Health is only one of its many objectives. The school may have general and special supervisors, and the nurse supervisor bears the same relation to the administrator as the other special supervisors. Moreover, there is a trend away from special supervisors which may account for the small number of nurse supervisors found in schools. There is also a definite trend toward the supervising principal; that is, the principal who sees his teachers every day, and is expected to offer individual and group help in the improvement of instruction. In this situation the general and special supervisors are educational directors, so to speak, to the group of principals, in order to help them become better supervisors in all aspects of education. The supervisor of nurses must understand and employ the same methods and avenues of supervision utilized by the other supervisors. She, too, must work with and through the principals.

There is another aspect of supervision in school health work which needs to be considered, especially in those schools where there is no director of health education—the supervision of teachers in matters pertaining to health. The nurse supervisor in her work with principals gives thought to the performance of teachers as well as of nurses. To put it in a different way, the nurse works through the principal, her object being to help all members of the school personnel—teachers and nurses—acquire a better understanding of the whole child. This is one of the essential principles of education, and

closely allied to it is the need for recognizing and dealing constructively with individual differences in children. Differences in growth and development, in susceptibility to illness, in emotional and social adjustment, in family background, and in traditional health behavior are among the factors with which the school principal, the teacher, and the nurses are jointly concerned. These factors are ever present during the twenty-four hours of the day. Therefore, supervision will seek to effect a close integration of health experiences in home and at school. Thus, parent education in matters pertaining to health becomes one objective of supervision.

Any program of supervision of the nurse in schools must be based on a thorough knowledge of the philosophy and purposes of the school in order that the nursing service may become an integral part of the total educational program of the school. The superintendent of education, together with his staff of supervisors and principals, determines general policies. The budget is, of course, a factor which must be considered before objectives and methods of supervisors can be determined.

The next step is the administration of the supervisory plan. No supervision can be effective without administrative assistance. The administrator seeks help from his technical advisers. In health matters these will be the physician, the nurse or nurse supervisor, and a representative of the department of health. These advisers help the school recognize the need for medical authority in determining school policies involving the management of emergencies of illness and injury and involving ethical relationships which have been set up for the protection of the public against exploitation. The administrative plan of supervision should therefore bring together these various interests into a unified whole.

A supervisory program must have some definite, long-time objectives considered of vital importance by all members of the organization—from the director all along the line to the new staff worker and the office clerk. The development of these objectives is often accomplished through staff participation in all aspects of the staff education program—in planning, executing, evaluating, and recommending changes in standards and policies. Group thinking goes on most effectively when there is a fair degree of homogeneity of interest and background among the group. It is often of advantage to divide the staff into small groups on the basis of interest and experience. The supervisory program can then be planned to meet individual needs, building on past experiences and integrating actual practice with theoretical knowledge discussed in staff conferences.

Staff supervision should be based on a manual which represents the best thinking of the group with reference to standards, policies, and procedures. The manual is continuously revised as new knowledge is discovered through scientific research, as practical applications of science are made, as the staff advances in its ability to apply knowledge and techniques to the solution of problems, and as community needs change. The supervisory program goes beyond the manual, in that it calls to the attention of the staff newer trends and new emphases, and shows how these may be applied to local situations.

THREE METHODS OF SUPERVISION

Supervision is carried on through three main channels—individual and group conferences, examination of records, and observation of staff workers.

The purpose of the individual conferences is to give specific help to each worker in understanding and applying the principles of science and preventive medicine to the arts of nursing and

health supervision. These individual conferences should not be superimposed. The effective supervisor will know the art of helping people so well that her assistance will be sought as it is needed —not only at intervals set aside by the supervisor. In order to be ready to give help, the supervisor will know her group. She examines credentials. She observes the nurse in all aspects of her work. She may give pretests on scientific facts and principles to stimulate the staff to self-evaluation. She comes to her individual conference with all of these facts at hand. And at definite periods she prepares a progress report of each worker which is discussed and restated if necessary, and which finally becomes a part of each worker's credentials for future reference. The purpose of this progress report, sometimes called an "efficiency report," is intelligent self-evaluation and self-correction.

Group conferences take various forms but they are based on individual needs no less than the individual conference. Needs of the field are discovered through surveys of economic, social, racial, and health conditions; through supervisory visits to schools, homes, and clinics; through individual conferences with nurses and teachers, and through observation of health instruction. Whatever method of group conference is used, it is planned to give the staff worker ample opportunity for self-expression. Some of the more common methods employed are pretests of their knowledge, used for motivation; demonstrations which present comparative methods rather than only one "best way"; the panel discussion, used to develop group thinking on controversial issues; the symposium, used primarily for the discussion of various aspects of a vital topic. Outside speakers may be brought in as needed for the development of selected topics. Field trips to coöperating agencies are also used, preceded and followed by discussion in order that practical applications are made to existing conditions.

In conclusion, the highest realization of the purposes of nursing will ultimately depend upon the work of the staff. Among the desirable outcomes of supervision are:

1. An ever-growing staff, increasing in ability in self-analysis and self-initiative.

2. A broader concept of supervision and an eagerness to seek guidance as needed.

3. A wide variety of materials of instruction available to all members of the staff and used voluntarily.

4. A continuous re-evaluation of standards, policies, and techniques in written form for the improvement of the service.

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Building the Health of Future Teachers

By MARGARET B. MILLER, R.N.

The health program of this Minnesota teachers' college is based on policies developed by a health committee representing the departments especially interested in student health

EACH FALL the college health program of Winona State Teachers College begins with the announcement, at the first assembly, of plans for the medical examinations. On every evening from seven to nine, groups of students are scheduled for these examinations. With five or six doctors working, six or seven evenings are required for the student body of approximately 400. The examinations are given annually and consist of a general physical survey; the taking of blood pressure; a special examination of eye, ear, nose, and throat; a complete urinalysis; and a hemoglobin reading, with more complete blood tests when indicated.

Recommendations are made regarding more complete examinations, correction of defects, restricted activity, and whatever else the findings seem to indicate. It is important to have these examinations completed before the activity classes in physical education and athletics begin. The college uses the Winona Clinic for this service because it comprises the only group of physicians working together in the city and has the only quarters and facilities adequate for caring for groups promptly. The fee of $1 a student for the examination comes out of the student activity fund.

STUDENT CONFERENCES WITH NURSE

Within the first month of school, all entering students make appointments with the college nurse for conferences of ten or fifteen minutes in length. At this time their medical examinations are interpreted to them, their general health habits discussed, and any personal problems taken up. Appointments are given for smallpox vaccinations if students have not been successfully vaccinated before, for other immunizations desired, and for any medical attention needed. Our experience indicates that these individual conferences probably do more in the way of health guidance than any other phase of the health program. As an example, it is always interesting to see the increase in the consumption of milk in the dormitories as these conferences progress.

All entering students also are given a special posture examination by the physical education department. This consists of a silhouettograph accompanied by an examination of the back and feet. It is followed by conferences, and assignment to corrective classes.

Another routine procedure early in the school year, usually in the first two or three weeks, is the Mantoux test. The superintendent of the bi-county tuberculosis sanatorium in this area, assisted by his field nurse, gives these tests at the college. The survey includes all students, faculty members, pupils in the training school, janitors, engineers, maids, cooks at the dormitories, and in fact all persons who are in any way connected with the college.

All those having positive reactions are x-rayed, and have x-rays taken each year—or more frequently if so advised. The x-rays are taken at the sanatorium because of the reduced cost. This insti-

tution is located thirty miles from the college and the school bus is used for transportation. The sanatorium, through the Christmas Seal fund and the two county public health associations, finances the testing and also the x-rays of persons whose residence is in one of the two counties. The health fund of the college pays fifty cents each for the x-rays of other persons. Individuals pay the cost of their own transportation to and from the sanatorium, which is reduced by the use of the school bus. In the years that this program has been carried on, eight students with tuberculosis have been discovered. Only three of these, however, needed to drop out of school. Since the others had no symptoms and the disease was not communicable, they remained in school on a restricted program, under the direct supervision of a physician. Had only one student with active tuberculosis been found in these years, the college would still feel that the program is very much worth while. Then, too, it is an excellent means of educating a group of people who will have a great influence upon the attitudes of our future population.

Inasmuch as the college is small, the health staff is correspondingly small. The college nurse is the only person whose full time is devoted to health work. She has full faculty ranking and her work is administrative, advisory, and educational. The care of ill students in the dormitory infirmary and in their rooming houses is given by an assistant, who is a graduate nurse and who takes a full program of courses in the college. For her service, which varies greatly from time to time, she receives full maintenance, tuition, and activity fees.

THE HEALTH COMMITTEE

The health policies are set up and administered by a group designated as the Health Committee, which is appointed by the college president. This committee is made up of the college nurse, the directors of the men's and women's physical education departments, the director of the training school, the head of the biological science department, and the director of the rural department. A few years ago the committee obtained the consent of the faculty to add an extra charge of $1.50 a quarter to the student activity fee, to be set up as a special fund for additional health service to the students. Under this new provision the students are now allowed each quarter the following:

1. Medical attention as frequently as needed at the college medical clinics held twice weekly.
2. Either one home call by a physician or one call at his office, with the approval of the health committee.
3. Hospitalization up to one week in emergency illness, and operating room charges, if surgical treatment is needed.
4. X-rays and care of injuries in case of accidents.
5. Special care under advisement of the committee of individual cases, not covered in the above.

The committee has decided for the coming school year to include in this service care of all athletic injuries. These have been previously cared for through the athletic association funds. The new plan should give better supervision over the health of the players, and should relieve the coaches of a great deal of responsibility in making decisions.

MEDICAL SERVICE TO STUDENTS

The medical service for the college clinics is arranged for through the county medical association. This organization was approached with our proposed plan, and a fee for the service was agreed upon. A list of the city physicians who wished to enter into the plan was given to us by the association. One physician serves for a term of three months. Unless the student chooses another doctor, this physician is called for home visits during the period of his service, and students are sent to him at his office when necessary between college clinics.

Only hospitalization in the city is paid

for. Occasionally a student lives near and prefers to have his operation in his home town. In this case the college assumes none of the expense, except perhaps the original physician's call and the laboratory charges. The committee has discussed this question repeatedly but has always come to the same decision that the only way to control the matter is to keep it local.

The provision for the care of injuries is very inclusive; for instance, during the past year over $150 was paid for repair of accidentally broken teeth alone. Minor emergency surgery that cannot be done at the college and that does not need hospitalization comes under the category of individual cases handled by the committee, listed as number five above.

The college medical clinics take care of the great majority of medical needs. Besides examinations, consultations, advice, and prescriptions given, these clinics are used for immunizations, Wassermann tests, and similar services. Frequently minor procedures such as washing out ears, incising furuncles, and dressings of various sorts are done. Through this service the students do have a great many things done for them that would otherwise be left undone because of lack of funds and inconvenience. This plan sets up an educational situation as well as a service, for a great deal of information is given and good health practices are established. It gives an excellent opportunity for following up the medical examinations that are given in the fall.

Students who have been absent from classes for any reason must obtain a readmission permit from the college nurse before returning to class. The health office is open for this purpose an hour in the early morning and again in the early afternoon, beginning fifteen minutes before classes convene. This plan seems the best way to insure against the readmission of ill students to classes before they are well enough to return. It offers, furthermore, an opportunity for individual health teaching. And it helps to get illnesses reported at their beginning, since "approved permits" are issued wnen the illnesses have been reported; otherwise "unapproved permits" are given.

We appreciate that this plan will undoubtedly be questioned, as it has been in our own minds, in relation to its influence on self-direction. However, since our experience proves that students come to us without the ability to direct themselves wisely either for their own welfare or for that of others, we hope that this plan will lead the way to self-direction by helping the students learn to judge their own conditions and make wise decisions on conduct.

HEALTH COURSES

All students in the college are required to take a course in hygiene. It is a four-point course, given preferably in one of the quarters of the freshman year, by the health director and the college nurse. The coördination of this course with the health service and examinations is our constant aim.

A course in health education is now required of all four-year elementary school majors and is given as an elective for all other students. This course is taught by the health director and occasionally by the college nurse. It provides an excellent means of acquainting the prospective teachers with the health work of the elementary school where they can observe the unified health program carried out by the coöperation of the teachers and the college nurse. Some opportunity for practical health work with the children is offered.

It is hoped that in the near future a course in health education will be required of all certified teachers, since it is impossible in a short course early in the college experience to cover a sufficient amount of information or to develop a

teacher health-consciousness adequate for the great responsibility they must assume.

First aid is taught by the college nurse each fall quarter as a two-point course. It is required of all physical education majors and is elective for others.

Any college health program has a great many phases that are peculiar to itself, and the Winona program has been built little by little, from experience through the trial and error method. If our mistakes or successes will guide other small colleges in setting up more adequate health programs, our efforts will be serving one more purpose.

Courtesy of "All the Children"

Looking toward the future

STUDENTS IN APPROVED PROGRAMS OF STUDY

DURING the school year 1937-1938 there were approximately 3700 nurses studying public health nursing in the programs of study which met certain requirements in regard to theoretical and practical instruction, according to the standards of the National Organization for Public Health Nursing. About 2700 students were enrolled during the academic year and 1000 in summer sessions. Two universities reported enrollments of more than 500 during the academic year—Wayne and Columbia Universities. Five colleges and universities reported more than 100 students enrolled at summer sessions—the Universities of Michigan, Minnesota, and Syracuse, Columbia University, and George Peabody College for Teachers.

During these 12 months, 422 certificate programs were completed, and 238 bachelor's degrees and 17 master's degrees granted.

Of the 2700 students attending during the academic year, almost half, 46.6 percent, had registered for the first time at the institutions reporting them as 1937-1938 students.

Social security stipends assisted 22.1 percent of the public health nurses enrolled during the academic year. Of those who received certificates, 23.9 percent had used social security stipends during the year.

STUDENTS IN APPROVED PROGRAMS OF STUDY IN PUBLIC HEALTH NURSING

	1937-1938	1936-1937
Number of approved programs of study	19	18
Total registration*	3706	3509
Academic year*	2712	2466
Summer session*	994	1043

Three additional programs of study were approved during 1938, those at St. Louis University, St. Louis, Mo.; New York University, New York, N.Y.; and Duquesne University, Pittsburgh, Pa. Students registered in these universities are not included in the totals above.

NUMBER OF PUBLIC HEALTH NURSING CERTIFICATES AND DEGREES AWARDED IN APPROVED PROGRAMS OF STUDY, 1937-1938*

State	Program of study	Certificates	B.S. or B.A. Degree	M.S. or M.A. Degree
Calif.	University of California Division of Nursing Education Berkeley	60	59	—
D.C.	Catholic University of America School of Nursing Education Washington	14	10	—
Mich.	University of Michigan Division of Hygiene and Public Health Ann Arbor	27	8	3
	Wayne University Department of Nursing Detroit	55	4	—
Minn.	University of Minnesota Department of Preventive Medicine and Public Health Minneapolis	6	40	—
N.Y.	Teachers College, Columbia University Division of Nursing Education New York	—	35	8
	Fordham University School of Social Service New York	3	—	—
	University of Syracuse Department of Public Health Nursing Syracuse	12	3	—
Ohio	Ohio State University School of Nursing Columbus	—	20	—
	Western Reserve University School of Applied Social Sciences Cleveland	44	—	4
Oreg.	University of Oregon Medical School Department of Nursing Education Portland	26	21	—
Pa.	University of Pennsylvania Department of Nursing Education Philadelphia	20	5	—
Tenn.	George Peabody College for Teachers Department of Nursing Education Nashville	48	12	1
	Vanderbilt University School of Nursing Nashville	14	3	—
Va.	Medical College of Virginia St. Philip School of Nursing Richmond	15	—	—
	College of William and Mary School of Social Work and Public Health Richmond	31	1	—
Wash.	University of Washington School of Nursing Education Seattle	42	17	1**
T.H.	University of Hawaii Honolulu	5	—	—
		422	238	17

*Exclusive of Simmons College, Boston, Mass., which did not reply.
**Degree of Master of Nursing.

A Program for Staff Education

Communicable Disease

By MARGARET G. ARNSTEIN, R.N.

THE WHOLE staff education program on communicable disease control may be presented in the form of questions which will stimulate discussion. In conducting the discussions the leader may have the group consider the following generalities as they may apply to specific problems under discussion:

1. There is often confusion in the minds of the public, and even of the nurse, regarding changes of procedure which are made from time to time, and also the variations in ideas and regulations found in different communities. The history of the communicable disease service illustrates very well how much our procedures must change to keep pace with a changing body of knowledge. Not only is it necessary to keep our own minds flexible, but it is important to teach others in such a way that they will be somewhat prepared when changes do occur.

2. In order to understand our present concepts and practices regarding the communicable diseases, it is necessary to have a knowledge of the history of the diseases and to be familiar with the facts known and theories advanced concerning them in the past; for ideas of the past linger on, even after science has thoroughly disproved them, and such ideas will be found in practice today in many communities.

3. The interpretation of the action to be taken in relation to well known facts may differ, and thus one finds varying practices based on the same thorough and up-to-date knowledge of the disease. For example, if three studies show that whooping cough vaccine reduces the severity of the disease, and two others do not show the same results—one health officer may consider these data sufficient evidence to warrant the incorporation of immunization against whooping cough into the health department program, while another may decide to wait for further evidence.

OUTLINE OF SUGGESTED CONTENT*

I. In general, public health departments are trying to reduce mortality and morbidity and improve health. In the communicable disease service how are these aims accomplished?
(NOTE: Generalizations about the control of communicable disease must be made with care since different methods are used in different diseases.)

- A. The organism can be intercepted in passage from one person to another.
  1. What procedures are designed to intercept the organism?
     Isolation, quarantine, disinfection
  2. Against what diseases is this method used as the main weapon?
     (This question may be raised here, but a full discussion is better saved until later.)
- B. The resistance of the host can be increased.
  1. How is resistance increased?
     A discussion of active and passive immunization, how produced, what they mean
  2. For which diseases is this the main method of attack?
     Smallpox, diphtheria
  3. Why is this method not used in the

*NOTE: In many cases partial answers have been given for the questions raised here, or suggestions have been made regarding the direction of the discussion.

general population in northern states, for protection against typhoid fever?

4. What groups should be immunized? Discussion of bases for decision—the risk of exposure to the disease and the susceptibility of the population.

C. If the first two methods fail or cannot be carried out with the present amount of knowledge, the ill effects of the disease can be minimized.
Examples: Care of scarlet fever to prevent complications, care of pneumonia, antitoxin for diphtheria

In order to accomplish any or all of these procedures, education must be carried on among all persons in the community.

In selecting the method of choice for combatting each disease an attack is made on the weakest point in the chain of events leading from disease in one person to disease in another. Epidemiological investigation tries to find this weakest point. A discussion of records and the studies which have been made, often leading to new practices, may be taken up at this point but probably is better postponed until the last meetings.

II. What are the specific activities of health departments?

A. Action to secure the reporting of communicable disease—taken by local health departments, state health departments. Why are communicable diseases reported?

1. In order that the patient, family, and community may be instructed in measures they may take to protect themselves and others. How is this instruction given?

2. In order that authorities may be informed of the incidence and location of cases of communicable diseases so that appropriate community action may be taken where necessary—apart from the action which is always taken for each case
Example: If a number of cases of typhoid fever (or septic sore throat) occur in the same locality they are often due to a common source such as the water or milk supply, and the health department in addition to preventing the spread from patient to patient must take action to find the common source and abolish it.

3. In order that data may be accumulated giving us further knowledge of the epidemiology of these diseases so that regulations may be made to fit the facts
Example: A study is made of measles—the age of incidence and age of deaths.

B. Provision for the diagnosis of suspected communicable disease cases

1. How important is this provision?

2. What is the provision in your community? In five other communities in other states or in your state?

C. Other activities of the health department for the control of communicable diseases

1. Sanitation
For which diseases is this our most important control measure? (Typhoid fever, dysentery, yellow fever, et cetera.)
What part has sanitation played in the control of communicable diseases?

2. Immunization
Is this a function of the health department? A debate might be arranged on this subject.

3. Education
Education is an expensive method of control; why use it?

4. Supplying biologicals
What is the justification, if any, for this practice?

5. Furnishing hospital care
What is the justification, if any, for this practice?

D. Public health nursing activities

1. Considerations upon which program plans are based, and upon which a day-by-day selection is made of patients to be seen

2. Could present nursing practice be improved? Is it up to date in methods of instruction, material taught, and techniques?

3. Does the communicable disease service take a reasonable proportion of the total time of the nurse's program?

4. A consideration of the causes of death: the relative importance of communicable disease causes and

other causes of death and physical handicaps; the preventability of each. A study of the effectiveness of the procedures used in relation to the expense and the time involved

5. What is the public health nurse's part in reporting communicable disease: in general? in your area? Does it differ for the department of health nurse, the school nurse, and the visiting nurse association: in theory? in practice? What is the citizen's obligation in regard to reporting suspected communicable disease?

6. One way for the public health nurse to approach the problem is by a discussion of communicable diseases classified under the following categories:

   a. Diseases in which prevention should be the main emphasis. Why? (Because there are reasonably effective methods of prevention.) Examples:

   (1) Smallpox
   What is the public health nursing part in the program?

   (2) Diphtheria
   What is the public health nursing part in the program?

   (3) Typhoid fever, hookworm, and other diseases (in areas where these diseases are prevalent)

   (4) Scarlet fever, measles (for certain age-groups)
   Specific preventive measures are used against these diseases in certain places, but are not as yet in general use.

   b. Diseases in which nursing care is the most important public health nursing activity. Why?

   (1) Measles
   (2) Whooping cough (in infants)
   (3) Pneumonia
   (4) Scarlet fever (severe)
   (5) Poliomyelitis

   c. Diseases in which education of the public in the need for *early* medical care is the most important consideration

   (1) Pneumonia. Why?
   The physician is often called when the disease is well advanced; serum therapy is *most* useful *early* in the course of the disease.

   (2) Measles
   Early medical supervision is especially important for young children, and in cases where there are young, exposed children in the household.

   (3) Whooping cough
   Early medical care is important for the young child, especially for the infant.

   d. Diseases which are not of great concern to the public health nurse. Why?

   (1) Chickenpox
   (2) German measles
   (3) Mumps (except possibly in adolescents and adults)

7. A discussion of the value of isolation and quarantine for various common communicable diseases is useful. Diseases might be classified in three categories according to the degree of strictness in measures which should be taken for isolation and quarantine:

   a. Strictest measures. Why?
   (1) Diphtheria
   (2) Scarlet fever
   (3) Smallpox
   (4) Others

   b. Less strict. Why?
   (1) { Measles
   { Whooping cough
   (2) { Pneumonia
   { Poliomyelitis
   What are reasons respectively for isolation in the diseases under group (1) and under group (2)?

   c. None
   (1) Chickenpox
   (2) German measles
   (3) Mumps
   Why are these of any concern to the health department? Why are they reported?

   Why are scabies and impetigo not reported in most areas?

8. A discussion of the derivation of techniques for the home care of communicable disease patients based on the facts brought out in the above discussion. All known data regarding the disease should be kept in mind, including its present-day severity or mildness, and the fact that some diseases apparently go through cycles of severity and mildness.

9. What are some of the reasons why it is hard for a nurse to plan for a communicable disease service and why it may be hard to keep up to date?

a. It is a sporadic service; even large cities have great unevenness of case loads at different seasons and in different years.

b. It is an emergency service; cases occur more or less suddenly, sometimes in large numbers, and must be seen at once. Judgment is needed—based on all known facts—as to where time can most effectively be spent.

c. In rural areas there may be long periods without one or more types of communicable disease. The alertness of the community and nurse to this hazard is dulled, and the nurse gets no practice in caring for the disease.

d. The body of knowledge regarding communicable disease is still changing very fast as new facts are brought to light through research, and old theories have to be discarded.

SUGGESTED PROBLEMS FOR STAFF DISCUSSION

These suggestions are given merely to show some types of problems which lend themselves to discussion. It is much better for the organization to discuss problems which have arisen in its own community providing there are situations which illustrate general principles.

1. Compare regulations for the control of communicable diseases in different states—preferably in different parts of the country. The following are suggested: your own state, New York, Minnesota, Tennessee. These have been chosen because they show rather divergent regulations. The regulations may be obtained by writing to the state departments of health.

Using the staff education program as a guide, discussion may be directed toward finding the reasons for the various regulations in view of the facts known today regarding the disease, and the facts known about it in the past.

Hints for lines of approach: Public health measures such as sanitation and immunization have changed the status of certain diseases. Further research in bacteriology and epidemiology has changed our conception of certain diseases. The diseases themselves have changed in severity. Changes in regulation have not always kept pace with changes in knowledge.

2. A measles epidemic breaks out in a semirural community of 7000 population. There is only one public health nurse in the community. What should she do? How should she plan her program? If the only nurse is a school nurse, what steps should she take?

3. Your state or city is undertaking a pneumonia program. Facilities for typing serum have been improved, and serum is being supplied.

What can a visiting nurse association in an urban area do to improve its service?

How can a county nurse working in a county with a population of 10,000 and a territory of 1000 square miles plan a pneumonia nursing program? What will it include? What new activities will she take on? What old ones will she increase or change? How much nursing care can she offer?

4. A principal (or teacher) in a centralized (or rural) school has called the county nurse because there is a case of scarlet fever (or a case of whooping cough, or a few cases of measles) in her school. What should the county nurse do? What instruction will she give the principal and teachers?

5. Take an epidemiological investigation form and discuss the reason for each item on it. What will the result be if the questions are not answered accurately?

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A School Uses Its Community Agencies

BY ROBERT L. DAWSON

A high school works out a plan for using its community resources to meet the needs of its pupils

HOW CAN our community agencies serve the various needs of our pupils? In an attempt to answer this question, a simple but workable plan has been tried out in the Knox Junior High School in Johnstown, New York.

The first step in the plan was the establishment, within the school, of a coördinating committee which serves as the school authority in dealing with specific individual pupil needs. This committee consists of the school nurse, who is in daily contact with both in-school and out-of-school conditions; the guidance counselor, whose work makes him intimately familiar with the personal problems of pupils in school; and the principal, whose position enables him to view the needs of pupils from the broader angle of the school as an institution, in its relationship to the community which it serves.

The second step was to acquaint ourselves with all of the city, county, and state agencies, whose objectives include the rendering of service to boys and girls of preschool and school ages. We listed forty-three different institutions and organizations which serve the human needs of many people living in our community, in one capacity or another.

In making this survey of community resources, a simple questionnaire was

used in which three questions were asked:

1. List the chief aims or objectives of your agency, institution, or organization.
2. Exactly how does your agency, institution, or organization attempt to serve the individual needs of school pupils?
3. Without the use of names, briefly describe one case which has come under your observation.

There was a splendid response to this short questionnaire. The directors of the several agencies responded with enthusiasm to the opportunity to report on the aims of their agencies and the services available through them.

The school coördinating committee then surveyed carefully all of these agencies to ascertain the kind and quality of service each was able and willing to provide for school pupils, and when this information was obtained it was classified under specific headings.

We first asked ourselves, what are the human needs of youth, and we grouped them very crudely in two general categories: the necessities of life, and the social and cultural needs. These two main classifications were then subdivided, for practical working purposes, into the following subheadings:

1. Necessities of life
   - Food
   - Clothing
   - Shelter
   - Fuel
   - Medical care
   - Dental care
   - Nursing service
   - Hospitalization
2. Social and cultural needs
   - Religious training
   - Wholesome social contacts
   - Home training
   - Liberal cultural association
   - Civic and citizenship responsibilities
   - Personal guidance
   - Wholesome recreation
   - Social recognition

The third step was the process of bringing the problems of pupils to the attention of the agency rendering the kind of service which will meet the particular need of each. This was the function of the school coördinating committee. Thus the wealth of available community service is used in a way which meets the varying needs of school pupils.

We have had the pleasant experience of discovering that out-of-school or community agencies are not only willing to serve, but appreciate the opportunity to give service when approached by some responsible authority for the type of aid which their organizations are able to render to youth.

THE AMERICAN JOURNAL OF NURSING FOR SEPTEMBER

Wood Tick Paralysis.....Kathleen Newton, R.N.
A Dollar's Worth for a Dollar.....Frederick MacCurdy, M.D.
A New Incubator.....Charles C. Chapple, M.D.
What Does a School Nurse Do, Anyway?.....Marie Swanson, R.N.
Two Business Meetings in London.....Julia C. Stimson, R.N.
Disinfection in the Home (Chemical Disinfectants).....Martin Frobisher, Jr., Sc.D.
Care of Fractures.....Barbara B. Stimson, M.D. and Delphine Wilde, R.N.
Nursing Legislation, 1939
Essentials of Parliamentary Procedure.....Bessie F. Barber
What Is a Collegiate School of Nursing?.....Isabel M. Stewart, R.N.
Faculty Growth.....John Dale Russell, Ph.D.

Your N.O.P.H.N.

This is the first of a series of articles on the National Organization for Public Health Nursing, written by the president and members of the staff

THE PURPOSE of this series of articles is to give a bird's-eye view and an inside view, both, of your National Organization. This series is to help you know what happens to your membership dollar day by day and month by month, and at the same time to bring you closer to the work of each staff member so that it may live for you as it does for us who are close to the N.O.P.H.N. in a concrete, tangible, and absorbing way. It is my privilege as president to introduce this series of articles.

A BIRD'S-EYE VIEW

The N.O.P.H.N. is a membership organization.

This is the first sentence that appears in many of our booklets, and that fact of membership influences all that we do.

In the hands of our members, who may be qualified public health nurses, lay people, or agencies, rests the election of our Board, its officers, and our Nominating Committee, and the planning of our program of work. Our members are a body at large, not classified by state or organization; the newest, youngest public health nurse in Alaska has the same privilege of direct vote as the oldest member of the oldest board of a visiting nurse association on the east coast. Any group of twenty members representing five different states may request and secure a meeting of our membership to consider any problem or to call for any kind of accounting they may desire. A change in our by-laws can be effected only by a vote of two thirds of our members after their due notification. Our Board is rotating; our dues subject to membership decision. And we are incorporated, bonded, and audited—all by vote of the members. The N.O.P.H.N. is *you*.

By your vote the N.O.P.H.N. Board is given power to select the general director of the executive staff and set her salary. She, in turn, is authorized to select her associate director and the staff and "run the business" within the budget designated by your Board.

At the present writing the executive staff consists of nine professional members and twenty-one secretaries and clerks. To the business manager is assigned the selection of the secretaries and clerks and all the business details of our office—such as ordering supplies, filing, and bookkeeping.

Each member of the professional staff is sufficiently "generalized" to answer the usual questions coming to her in the field and office, but each also has her specialties in which she is expert and on which she advises all the rest of the staff as need arises. You will hear from each of them in this series of articles.

Each member of the staff serves as secretary of at least one committee; thus each committee chairman can expect executive service from the N.O.P.H.N. office. The active program of the organization moves forward, as someone has said, "from the heads of our committees on the feet of their secretaries—the staff." Each committee is responsible to the Board—or its Executive Committee—for appointment and for reporting its work. Since the general director is an ex-officio member of every committee and secretary of the Board, she serves as a sort of general

switchboard and is responsible with the help of her associate for correlating, distributing, and forwarding the work of all committees.

Since our earliest inception, the N.O.P.H.N. has stressed the partnership of professional and nonprofessional workers. "Consumer-interest" has been fostered and safeguarded through membership and through representation on our Board, committees, and staff. No subject comes before the Board that is not analyzed and investigated by those who are served and those who serve. This dual interest focuses on what is the best public health nursing service for the patient—or more largely, the community—and no decision is made without taking the public need into account.

Public health nurses in nineteen states believe that the goals of public health nursing can be more directly gained by working through state organizations for public health nursing, separate from—but preferably used as sections of—the state nurses' associations. These state organizations of course include lay people as voting members; and when such an organization is recognized as a branch of the N.O.P.H.N. it sends a delegate to the National Organization's Council of Branches—of which Edna Hamilton of Michigan is chairman. We believe that the independence of action secured by a strong state branch of public health nursing and this relationship to the National are desirable, and we welcome branch membership.

Like other standard-making membership organizations, your N.O.P.H.N. is a voluntary agency. It receives no assistance from tax funds of any kind. It is free to stand for what you think is best.

With this introduction to your National Organization's place in the work of the world, I take pleasure in presenting in the next number of the magazine a report of what our general director does, written by her. It will in turn be followed by descriptions of special phases of the work of each member of your National staff. When this series is finished in the spring of 1940, I hope you will come to the Biennial Convention in Philadelphia ready to meet your N.O.P.H.N. in person and more than ever ready to share with the Board the planning of our national program for 1940-1942.

GRACE ROSS, R.N.
President, Board of Directors

SCHOOL REPORTS

A COMPLETE record of all student accidents resulting in lost time or doctor's care is kept by school systems with more than 800,000 enrollment. A summary of the accidents occurring in the seven months from September 1938 to March 1939, shows that 19 percent of them occurred in school buildings, 18 percent on school grounds, 7 percent going to or from school, 24 percent at home, and 32 percent at places away from school or home and outside school hours. Briefly, 44 percent occurred on school property or on the way to or from school, and 56 percent at other places.

—From *Accident Facts*, National Safety Council, 1939, p. 53.

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

BIENNIAL HEADQUARTERS

The 1940 Biennial Convention of the three national nursing organizations will be held in Philadelphia, Pa., May 12-18.

Headquarters for the National Organization for Public Health Nursing will be at the Bellevue-Stratford Hotel. Headquarters for the American Nurses' Association and the National League of Nursing Education will be at the Benjamin Franklin Hotel.

The rates per day at the Bellevue-Stratford Hotel are as follows: single rooms with bath, $4.40; single rooms without bath, $2.50 and $3.50; double rooms with bath, $5, $6, $7, and $8; suites, from $13.20 to $19.80. At the Benjamin Franklin Hotel the rates per day are as follows: single rooms with bath $3.50, $4, $4.50, and $5; double rooms with bath, $5, $6, and $7.

For further information about Philadelphia and its environs write to Mrs. Adelaide W. Pfromm, chairman of the Local Arrangements Committee, 1431 North 15 Street, Philadelphia, Pa.

SPECIAL ARRANGEMENTS

Groups desiring special detailed information about breakfasts, luncheons, or dinners may write to Katie Walton, Philadelphia General Hospital, Philadelphia, Pa.

HONOR ROLL

The Honor Roll goal for 1939 is 1000! With the addition of the 153 agencies listed below, we now have a total of 854 Honor Roll agencies. Without a doubt this list would be much longer if all the agencies eligible would notify us, but we think it is indeed a list to be proud of.

Don't forget that any nursing staff whether of school, industry, health department, visiting nurse association, or any other organization is eligible. And one-nurse services too! Be sure to notify us as soon as your staff is 100 percent enrolled. That is the only way we have of knowing when to send your Honor Roll Certificate and to add your name to our growing list of 100 percent agencies. We need each one of you to reach our 1000 goal!

ALABAMA
- Cherokee County Health Department, Center
- Clarke County Health Department, Grove Hill
- Crenshaw County Health Department, Luverne

ARKANSAS
- Yell County Health Department, District No. 9, Danville
- *Metropolitan Life Insurance Nursing Service, Little Rock

ARIZONA
- Prescott Community Nurses Association, Prescott
- Yuma County Public Health Unit, Yuma

CALIFORNIA
- Madera County Health Unit, Madera
- California Tuberculosis Association, San Francisco
- Santa Cruz County Health Department, Santa Cruz

COLORADO
- Morgan County Public Health Nursing Service, Fort Morgan
- State College of Education, Greeley
- Pueblo City Health Department, Pueblo

CONNECTICUT
- Bridgeport Branch of the Connecticut State Child Welfare Bureau, Bridgeport
- Groton Visiting Nurse Association, Groton
- Public Health and Visiting Nurse Association, Meriden

DISTRICT OF COLUMBIA
- Kiwanis Club Clinic for Crippled Children, Washington

FLORIDA
- Hernando County Public Health Nursing Service, Brooksville

*Agencies which have been on the Honor Roll list for five years or more.

Dixie County Public Health Nursing Service, Cross City
State Board of Health, District No. 2, Jacksonville
Jackson County Health Department, Marianna
*Escambia County Health Unit, Pensacola
Gadsden County Health Department, Quincy

GEORGIA

*Metropolitan Life Insurance Nursing Service, Atlanta
Worth County Health Department, Sylvester
Metropolitan Life Insurance Nursing Service, West Point

ILLINOIS

Metropolitan Life Insurance Nursing Service, Cairo
*Chicago Tuberculosis Institute, Chicago
Tuberculosis Sanatorium Board of Lee County, Dixon
Stephenson County School Nursing Service, Freeport
Mason County Public Health Nursing and Tuberculosis Association, Havana
Board of Education, Hinsdale
Hygienic Institute, LaSalle
Metropolitan Life Insurance Nursing Service, Oak Park
Cheerful Home Association, Quincy

INDIANA

Metropolitan Life Insurance Nursing Service, Gary
Visiting Nurse Association, Muncie
*Hygiene Department, Terre Haute City Schools, Terre Haute

IOWA

Ames School Nursing Service, Ames
Boone County Nursing Service, Boone
Health District No. 2, Iowa State Department of Health, Centerville
Clarinda School Nursing Service, Clarinda
Scott County Nursing Service, Davenport
Decorah School Nursing Service, Decorah
Polk County Health Unit, Des Moines
Eagle Grove School Nursing Service, Eagle Grove
Harlan School Nursing Service, Harlan
Humboldt School Nursing Service, Humboldt
Iowa State Services for Crippled Children, Iowa City
Jefferson School Nursing Service, Jefferson
Marion County Nursing Service, Knoxville
Plymouth County Nursing Service, LeMars
*Community Nursing Service of Marshalltown, Marshalltown
Mason City School Nursing Service, Mason City
Monona County Nursing Service, Onawa
Clarke County Nursing Service, Osceola
Perry School Nursing Service, Perry
Sac County Nursing Service, Sac City
Osceola County Public Health Nursing Service, Sibley
Washington County Nursing Service, Washington
Webster City School Nursing Service, Webster City
East Waterloo Public Schools, Waterloo

KANSAS

Allen County Visiting Nurse Service, Iola
*Visiting Nurse Service, Kansas City
Winfield Board of Education, Winfield

KENTUCKY

John Hancock Mutual Life Insurance Company Nursing Service, Newport
Powell County Health Department, Stanton

LOUISIANA

Allen Parish Health Unit, Oberlin

MAINE

Augusta Red Cross Nursing Service, Augusta

MASSACHUSETTS

Hanover Visiting Nurse Association, Inc., Hanover
*Lynn Visiting Nurse Association, Lynn
*Instructive Nursing Association of New Bedford, New Bedford
Sudbury Public Health Nursing Association, South Sudbury

MICHIGAN

Alger-Schoolcraft Health Department, Manistique
Central State Teachers' College, Mount Pleasant

MINNESOTA

Arrowhead Unit, District No. 4, Duluth
District Office, Minnesota Department of Health, Mankato
Division of Child Hygiene, Minnesota Department of Health, Minneapolis
*Community Health Service, Minneapolis
Hennepin County Nursing Service, Minneapolis
Division of Services for Crippled Children, State Board of Control, St. Paul
White Bear Public Schools Nursing Service, White Bear Lake

MISSOURI

Metropolitan Life Insurance Nursing Service, Cape Girardeau

MONTANA

Metropolitan Life Insurance Nursing Service, Billings
Metropolitan Life Insurance Nursing Service, Great Falls
Metropolitan Life Insurance Nursing Service, Missoula

NEBRASKA

Lincoln and Lancaster County Chapter, American Red Cross, Lincoln
Demonstration District Health Unit No. 2, Norfolk

NEVADA
*Nevada State Department of Health, Reno

NEW HAMPSHIRE
Bradford School Nursing District, Bradford

NEW JERSEY
Hudson County Metropolitan Nursing Service, Jersey City
Essex County Girls' Vocational School, Newark
Dover Township Board of Education, Toms River

NEW MEXICO
Hobbs Municipal Schools Nursing Service, Hobbs
*State Department of Public Health, Santa Fe

NEW YORK
Metropolitan Life Insurance Nursing Service, Auburn
*Visiting Nursing Association of Buffalo, Buffalo
Orange County Committee on Public Health, Goshen
Gowanda Red Cross Nursing Service, Gowanda
Cattaraugus Health Department, Olean
*Visiting Nurse Association, Syracuse
Onteora Chapter, American Red Cross, Tannersville

NORTH CAROLINA
Metropolitan Life Insurance Nursing Service, Charlotte
Ashe County Unit, District Health Department, Jefferson
Davidson County Health Department, Lexington
Metropolitan Life Insurance Nursing Service, Rocky Mount
City of Salisbury and Rowan County Health Department, Salisbury

NORTH DAKOTA
Golden Valley County Health Department, Beach
Burleigh County Nursing Service, Bismarck
City Nursing Service of Bismarck, Bismarck
Burke County Nursing Service, Bowbells
Pembina County Health Department, Cavalier
Dickey County Public Health Nursing Service, Ellendale
*Cass County Health Department, Fargo
Sargent County Public Health Nursing Service, Forman
Grand Forks County Nursing Service, Grand Forks
Grand Forks Public Schools, Grand Forks
Traill County Health Department, Hillsboro
Stutsman County Public Health Nursing Service, Jamestown
Ransom County Public Health Nursing Service, Lisbon
Hettinger County Health Department, Mott
Eddy County Health Department, New Rockford
Barnes County Public Health Nursing Service, Valley City
City and School Public Health Nursing Service, Valley City
Richland County Health Department, Wahpeton

OHIO
Visiting Nurse Association of Cleveland, Branch No. 6, Cleveland
Shelby Public Health League, Shelby

OKLAHOMA
Carter County Health Unit, Ardmore
Metropolitan Life Insurance Nursing Service, Oklahoma City
LeFlore County Health Unit, Poteau
Metropolitan Life Insurance Nursing Service, Tulsa
Seminole County Health Department, Wewoka

OREGON
Linn County Health Service, Albany
Bend School Health Service, Bend
Deschutes County Health Service, Bend
Coos County Health Unit, Coquille
Lane County Health Unit, Eugene
Yamhill County Health Unit, McMinnville
Jackson County Health Department, Medford
*Clackamas County Health Unit, Oregon City
University of Oregon Medical School, Department of Nursing Education, Portland
Division of Public Health Nursing, State Board of Health, Portland
*Oregon Tuberculosis Association, Portland
Multnomah County Health Unit, Portland
Portland Visiting Nurse Association, Portland
Douglas County Health Unit, Roseburg
Tillamook County Health Service, Tillamook

PENNSYLVANIA
*Community Health and Civic Association, Ardmore
Giant Portland Cement Company, Egypt
*Henry Phipps Institute, Philadelphia
*Negro Bureau of Nursing, Philadelphia Health Council and Tuberculosis Committee, Philadelphia

RHODE ISLAND
*Bristol District Nursing Association, Bristol
*Visiting Nurse Association of Pawtucket, Central Falls, and Vicinity, Pawtucket

*Agencies which have been on the Honor Roll list for five years or more.

TENNESSEE

*Metropolitan Life Insurance Nursing Service, Chattanooga
*George Peabody College for Teachers, Department of Nursing Education, Nashville
State Department of Health, Nashville
Humphrey County District Health Department, Waverly

TEXAS

Runnels County Public Health Nursing Service, Ballinger
Pecos County Nursing Service, Fort Stockton
Tarrant County Health Unit, Fort Worth
*Galveston Public Health Nursing Service, Galveston
University of Houston, Houston

UTAH

Utah State Board of Health, Garfield County, Panguitch
*Utah Tuberculosis Association, Salt Lake City

VIRGINIA

*Prince Edward County Health Department, Farmville

WASHINGTON

Asotin County Health Unit, Asotin
Metropolitan Life Insurance Nursing Service, Bremerton
Pierce County Health Department, Tacoma

WISCONSIN

*Visiting Nurse Service, Attic Angels, Madison
Superior City Red Cross Nursing Service, Superior
Two Rivers Health Department, Two Rivers

WYOMING

State Department of Public Health, Cheyenne

INVITATIONS TO 1942 BIENNIAL CONVENTION

STATES that wish to invite the three national nursing organizations to hold the 1942 Biennial Convention in one of their cities are asked to meet the following conditions:

Before a state issues an invitation to the three national nursing organizations to hold a Biennial Convention in a specified city, *written* assurance must be presented to the three national nursing organizations, signed by the official representative of some responsible body or bodies, that facilities such as convention halls, exhibit hall, and additional meeting places are available free of charge. Also, that the nursing groups in the state (or states) are willing to coöperate in the undertaking.

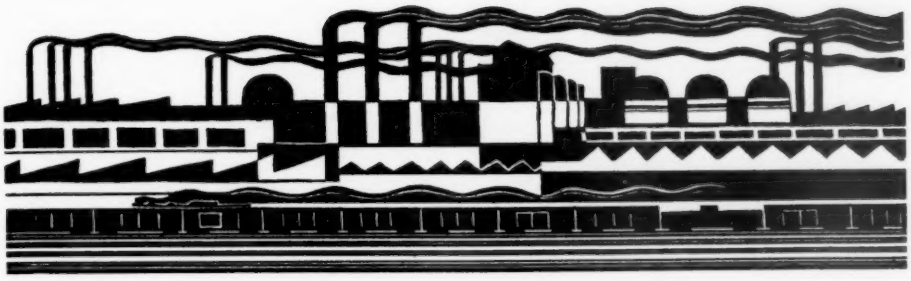
Invitations endorsed by the three state organizations—the state nurses' association, the state league of nursing education, and the state organization for public health nursing—where these exist, should be issued at least three months prior to the Biennial Convention at which the invitations are to be presented. The facilities offered by the city issuing the invitation should be carefully described, giving full details.

The Headquarters Biennial Convention Committee is to make sure that the question of the admittance of all nurses to meeting places regardless of their color, race, or creed, should be taken up with the mayor or the president of the chamber of commerce in those cities in which such questions might arise.

For further information write to Mrs. Alma H. Scott, chairman of the National Biennial Headquarters Committee, 50 West 50 Street, New York, N. Y.

TO SUBSCRIBERS

When you change your mailing address be sure to notify PUBLIC HEALTH NURSING, 50 West 50 Street, New York, N. Y., allowing at least one month before the change is to take effect. With your new address please send us the old one. Copies that have been mailed to an old address will be forwarded by the Post Office if you will send forwarding postage to the Post Office.



NURSING SERVICE FOR THE SMALL PLANT

A discussion of the use of part-time public health nursing service by the small industry

THE PROBLEM of health service for employees in small industries has become a matter of concern not only to health authorities but to workers and their employers as well. It is estimated that in this country there are fifteen million people who work in manufacturing, mechanical, and mineral industries. Of the more than eight million persons employed in manufacturing plants, sixty-two percent are working in establishments employing less than five hundred persons.* Most establishments of this size cannot afford to employ a full-time physician. Even employment of a full-time nurse seems impossible for many.

The Committee on Healthful Working Conditions of the National Association of Manufacturers is one group which has been studying this problem. Its members have become much interested in the possibility of purchasing part-time nursing service from local public health nursing associations to assist with health work in these small plants. The idea is not a new one, of course, since a few visiting nurse associations have served industrial establishments in this way for years. However, because of the increased interest now shown in the health of the worker, the time seems propitious for an extension of such activities by public health nursing associations. Some local agencies, realizing this opportunity for service, have asked the National Organization for Public Health Nursing for suggestions.

As a first step toward advising member agencies, it seemed wise for the N.O.P.H.N. to collect information from organizations that have had experience in this field. A letter was sent to all those whose reports for 1937 had indicated that they had any income from service rendered to industry. Replies received from twenty-two of the member agencies that are now giving industrial service seem of sufficient interest to share with others who may be considering contracts with industrial concerns.

NATURE OF SERVICE RENDERED

The first question asked of the agencies was this: Is the service which you give rendered within the plant, in homes of employees, or both? Nine agencies replied that services are limited to home visits to sick and injured employees. Occasionally a company pays the nursing agency for visits to the families of employees also. Five agencies reported giving service within the plant only, usually in the form of first aid and follow-up care of minor injuries. The remaining eight reported service both in

*Bloomfield, J. J. "The Nurse and Industrial Hygiene." PUBLIC HEALTH NURSING, November 1938, pp. 648, 649.

the plant and in homes of the workers. All twenty-two agencies stated that nursing care both in homes and plants is given only under the direction of a physician or in accordance with standing orders approved by the responsible physician or group of physicians.

BASIS OF PAYMENT

Another question was: On what basis are you paid for these services? Replies show that nine agencies receive compensation on the visit basis, the charge usually being determined by the cost to the agency of making a home visit. One agency receives each year twenty cents for each employee in the industries served; in return the nurses make all the home visits that are needed. Seven agencies that render service within plants are paid on a time basis. Five agencies receive a flat sum each year. Usually this flat sum is based on the number of employees and the service desired, or on an estimate of the time which will be required. Occasionally the amount paid seems to be arbitrarily set by the company served; sometimes the payment is made in more than one way, and for these agencies only the basis of payment of the largest source of income was counted in compiling this summary.

ORIGIN OF THE SERVICE

Though not all of the agencies could tell how their industrial service originated, an interesting variety of beginnings was shown. Sometimes the business concern itself initiated plans for service to its employees. More often perhaps it was the public health nursing association that first sought to make the arrangement.

At least on two occasions, employees of the industries concerned were responsible for securing nursing aid. In one company the service started through arrangement with a mutual benefit association. In the other firm the men in the plant asked for an up-to-date first-aid room and the part-time service of a nurse.

Stimulation from an outside source is reported in three instances. In one case this came from a nurse supervisor of an insurance company, and in another from a staff member of the N.O.P.H.N. In the third instance the United States Public Health Service used the local public health nursing association for some home visiting during a study of health hazards in the making of a factory product. When the survey was over the company continued to pay for visits.

Frequently payment for service has been reduced or discontinued in recent years because of the economic depression. Occasionally, however, the depression has been the occasion for securing a contract. Thus, one agency reports that depression conditions and the resultant reduction of personnel caused the closing of the medical department in a local industry; the management then made a contract with the visiting nurse association to supply a nurse at stated hours each week. Another agency reports: "When industrial conditions are good this mill has a full-time nurse; when fair, they buy hourly nursing service from us; when poor, an office employee gives first aid." Still another agency tells of a decision made by an industry to drop its group insurance; but since nursing service available through the insurance plan had proved valuable, the contract for nursing service was made directly with the nursing agency.

Apparently the Visiting Nurse Association of Chicago was the first of the 22 agencies to undertake industrial work. Its first contract was signed in 1903. The program included "first aid and interviews within the plant and visits in homes."

The Visiting Nurse Society of Philadelphia probably has developed the

largest industrial service, though it only began this type of work in 1932. Five plants are served at present, but at times the number has been greater. Just now a plan for extension of its work is under consideration. The number of employees in the plants served ranges from one hundred to five hundred people, and the industries buy from three to twenty hours of service weekly. Payment is planned to cover not only specific service rendered, but also nursing supervision and time used for record work in the visiting nurse office. A supervisor who is experienced in industrial nursing acts as a liaison person and each plant nurse has a substitute prepared to carry on the work in her absence. Services include assistance to the physician with routine physical examinations; follow up for correction of defects; general dispensary service, both surgical and medical; and general health supervision.

PLANS FOR EXTENSION

A number of agencies reported plans for extension of service when business conditions are better. One states: "When business returns to normal we will write a letter to all plants offering service. In this, we will have the cooperation of the manufacturers' association."

If one can judge from this small sample, the development of service to industry by public health nursing associations will have advantages for all concerned. For the nursing organization it provides an opportunity to give needed service to an important group in the community without additional drain upon agency budgets. For industry it offers an economical way of securing health service from especially prepared health workers. For industrial workers it makes available a health supervision which is now generally recognized to be greatly needed.

Health supervision by well qualified public health nurses can mean much more than just first aid. For example, one agency reports: "After some time and with repeated suggestions, the company was persuaded to insist upon employees wearing protective glasses in certain departments. This safety provision resulted within the first year in more than a fifty percent reduction of eye injuries from flying steel particles. Thus educational work goes on."

It seems probable that the future development of service from public health nursing associations to industrial concerns will depend upon the education of industrial management concerning the value and economy of such arrangements, and upon the availability in the agencies of nurses who are qualified for industrial work. Public health nurses in industry in addition to their usual public health nursing preparation and familiarity with community agencies need to have a thorough grasp of the techniques of surgical nursing and first aid and some knowledge of industrial hygiene.

RUTH HOULTON, R.N.
Associate Director, National Organization for Public Health Nursing

THE SCHOOL HEALTH PROGRAM

By C.-E. A. Winslow, Dr.P.H. 120 pp. The Regents' Inquiry. McGraw-Hill Book Company, Inc., New York, 1938. $2.

School nurses will be especially interested in the sections of this report dealing with mental hygiene in school health services. The report considers mental, emotional, and social as well as physical health, but nurses will be disappointed to find so little about school nursing. The recommendations include provision for: a health examination three times during the life of the school child, preferably by the family physician; an integrated health program, which the committee feels can best be provided when all phases of school health are under the jurisdiction of educational authorities; the direction of the program by a single responsible individual, qualified in the fields of both health and education; a representative committee to plan and develop the health program; and the interpretation to administrative authorities of the meaning of the school health program.

E. E. M.

PERSONAL AND COMMUNITY HEALTH

By C. E. Turner. 652 pp. The C. V. Mosby Company, St. Louis, fifth edition, 1939. $3

Dr. Turner, in preparing his fifth edition of *Personal and Community Health,* has improved a previous standard work by bringing many of his previous chapters up to date, and by enlarging some. Certainly the volume is a complete reference topically although it of necessity leaves something to be desired in the fullness with which some areas of hygiene are treated. Instructors who use it as a college textbook, for example, may find greater need for material in the areas of mental hygiene and social relationships. Many of the normal problems of emotional and intellectual control, courtship, and marriage are not treated as fully as college students will desire. Nevertheless, the material given is sound and provocative.

The general tone of the book is a reflection of the biological origins of health problems, and Turner continues the organization of chapters in terms of the hygiene of the great systems or of organic parts. College hygiene courses based upon functional problems of living will find the book's greatest use, therefore, as a reference providing factual material to explain the organic aspects of these problems. For that reason this fifth edition can be enthusiastically recommended to all instructors offering educational experiences in healthful living.

D. Oberteuffer
Columbus, Ohio

A MODERN PHILOSOPHY OF PHYSICAL EDUCATION

By Agnes R. Wayman. 231 pp. W. B. Saunders Company, Philadelphia, 1938. $2.25.

The author of this book presents a philosophy that is educationally sound. Her analysis of social trends in America shows how a physical education program based on the individual needs of boys and girls can help them face new situations which arise in their everyday lives.

An excellent background is given for understanding the aims of physical education and its relationship to health education. In this new philosophy of physical education, the emphasis is changed from winning teams, championships, record gate receipts, and large

grandstands to "physically educated" and "socially efficient" human beings. Because of this change in emphasis, health education—including physical development, emotional maturity, and socially acceptable behavior—receives a prominent place.

This book will be of special interest to school nurses who need to understand the new philosophy of physical education in order to assist the physical education teachers with their health programs and to guide individual pupils in meeting their health problems.

LULU V. CLINE, R.N.
South Bend, Indiana

THE HEALTH OF COLLEGE STUDENTS

By Harold S. Diehl, M.D., and Charles E. Shepard, M.D. 169 pp. American Council on Education, Washington, D. C., 1938. $1.50.

The authors report on a thorough survey of health problems of college students, tell how many colleges of various types are meeting those problems, and give suggestions for organization and development of college student health services. The facts and figures presented here provide something of a measuring stick for rating the many phases of college health programs. The reviewer urgently recommends this book to all who have a share in a college health program—college physicians, instructors of hygiene and physical education, college administrators, and especially college nurses.

RAIDIE POOLE, R.N.
Superior, Wisconsin

MENTAL HEALTH THROUGH EDUCATION

By W. Carson Ryan. 315 pp. The Commonwealth Fund, New York, 1938. $1.50.

This book is written in a nontechnical style which makes a definite appeal to the lay reader. It is a rather inclusive discussion of what is now being done in the field of mental hygiene. It gives the reader a feeling of growing awareness of an area of educational development which is assuming increasing importance. It convinces one whose work lies in the area of human relationships that he must take more account of the individual as a person and consider matters of mental health as well as physical and economic relationships. The ability of an individual to make adjustments in living his life is here shown to be of great importance. It includes a discussion of the school organization and its curriculum, and of family, school, and community relationships.

If the author could have given more space to a discussion of what are the *processes* of sound health, the book might have had greater value for many a worker in the fields of human interaction. How to develop ability to maintain integration within the self while living in a changing, troubled world is a thing teachers and social workers would like to be able better to teach to those with whom they work.

LOIS COFFEY MOSSMAN, Ph.D.
New York, New York

BE HEALTHY

By Katherine Bruderlin Crisp. 532 pp. J. B. Lippincott Company, Philadelphia, 1938. $1.56.

An excellent preface to this book states that the content is limited "to those health subjects that are considered to be of most immediate concern to high-school pupils. . . . The book lends itself to any type of health education program" as a textbook for reference.

At the beginning of each chapter are listed a dozen or more practical questions which are answered in the chapter. At the end of each chapter are self-testing aids. Health education is treated not as a subject to be taught by and of itself, but as an integral part of the total curriculum of the school. The first part of the book deals largely with personal hygiene. The last part discusses

community health and such subjects as accidents, mental hygiene, tobacco, alcohol, and patent medicines. Suggestions are offered for a health library.

The chapters are brief and concise, and the book has been made dynamic through the use of extremely well selected pictures, graphs, and charts, as well as by suggestions for many practical activities to apply the information in each chapter.

MILDRED TUTTLE, R.N.
Marshall, Michigan

A GIRL GROWS UP

By Ruth Fedder. 235 pp. Whittlesey House, McGraw Hill Book Company, New York, 1939. $1.75.

Perhaps one of the most important things in life is the ability to get along with other people. *A Girl Grows Up* is concerned with this problem, as well as with others involved in growing up emotionally and developing a satisfactory philosophy of living. The principles of psychology underlying certain fundamentals of behavior are discussed in a nontechnical way. Miss Fedder has a real understanding of the adolescent and presents this material in such a way that girls are led to think through their own problems and understand their emotional reactions.

This is a most worth-while book for older girls and should be of real interest and value to adults working with them.

MARION E. WARREN, R.N.
Audubon, New Jersey

SOCIAL SERVICES AND THE SCHOOLS

By Educational Policies Commission. 147 pp. National Education Association of the United States and the American Association of School Administrators, Washington, D. C., 1939. 50c.

This book is a report of the policies regarding the relationships of schools to allied social agencies, which are recommended by the Educational Policies Commission of the National Education Association.

Basic principles, as approved by outstanding experts in the appropriate field, are presented for guidance in the fields of education, library science, recreation, health service, and welfare service. Following a discussion of the nature of the social services, and an analysis of their interrelationships, recommendations are made for better community service through a closer coordination and use of existing facilities.

This book should be valuable to administrators in the five fields discussed, in the planning of future programs.

HELEN A. CARY, M.D.
Portland, Oregon

RECENT PUBLICATIONS AND CURRENT PERIODICALS

SCHOOL

THE MEANING OF INDIVIDUAL GUIDANCE. Herbert R. Stolz. *Journal of National Education Association,* September 1938, p. 189; October 1938, p. 194; November 1938, p. 240; December 1938, p. 277; January 1939, p. 19; February 1939, p. 55; March 1939, p. 69.

A series of articles on individual guidance, prepared by the Committee on Individual Guidance of the National Education Association.

LITTLE JOURNEYS AMONG HIGH SCHOOLS. Jean V. Latimer. *Hygeia,* September 1938, p. 839; October 1938, p. 949; November 1938, p. 1028; December 1938, p. 1131; January 1939, p. 72; February 1939, p. 163; March 1939, p. 260; April 1939, p. 377; May 1939, p. 474; June 1939, p. 570; July 1939, p. 666.

A series of articles describing health activities of interest to students in secondary schools.

HEALTHFUL SCHOOL LIVING. National Tuberculosis Association, New York, 1938. 15 pp. Order from your state or local tuberculosis association.

This material was prepared as a guide to school administrators, supervisors, and teachers in the improvement of school living con-

ditions. It emphasizes certain essentials without which healthful school living cannot be maintained.

BETTER WASHROOMS. *The Nation's Schools*, January 1939, p. 33.

The Journal of School Health, November 1938.

Six articles on tuberculosis case finding and control in schools and colleges are included in this issue.

TEACHING AIDS FOR TEACHERS. Mary Dabney Davis. *School Life*, February 1939. Available in reprint form from U. S. Government Printing Office, Washington, D.C.

THE COLLEGE STUDENT AND DORMITORY STUDY FACILITIES. Anette M. Phelan. *Sight Saving Review*, March 1939. Reprint available from National Society for the Prevention of Blindness, 50 West 50 Street, New York, N. Y. 10c.

A description of reading and study facilities conducive to eye health.

GUIDES FOR PUBLIC HEALTH NURSES. Family Health Series, No. 5 Posture. Community Service Society of New York, 105 East 22 Street, New York, N. Y., 1939. 5c.

An outline which will assist nurses in making health inspections and in teaching the value of good posture and methods of improving posture.

INDOOR AND OUTDOOR PLAY ACTIVITIES FOR THE SCHOOL, HOME, AND COMMUNITY. Healthful Living Series, Bulletin No. 2. Issued by State Department of Public Health, with the approval of State Department of Education, Santa Fe, N. Mex., 1938. 19 pp.

A brief discussion of the importance of play and suggestions for games and play activities which do not require expensive equipment.

HEALTHFUL LIVING THROUGH THE SCHOOL DAY AND IN HOME AND COMMUNITY. Nina B. Lamkin. Healthful Living Series. Bulletin No. 1. Issued by State Department of Public Health with the approval of the State Department of Education, Santa Fe, N. Mex., 1939. 71 pp. Free.

This bulletin contains numerous suggestions for health projects which may be planned to promote healthful living.

SAFETY EDUCATION IN INDUSTRIAL SCHOOL SHOPS. Prepared by Dr. Paul L. Cressman. Bulletin 332. Department of Public Instruction, Harrisburg, Pa., 1938. 87 pp.

This is the report of a study of accidents in school shops in Pennsylvania, and includes recommendations for a safety education program.

THE PROBLEM SOLVING APPROACH IN HEALTH TEACHING. School Health Bulletin No. 2. The Michigan Joint Committee on Health Education, Haven Hall, Ann Arbor, Mich., 1937. 31 pp. 10c outside State of Michigan.

An outline of health activities in which pupils, teachers, and parents may coöperate in discovering and solving the actual health problems of home, school, and community. A helpful guide to planning a school health program.

THE DENTAL PROBLEM OF ELEMENTARY SCHOOL CHILDREN. Henry Klein, D.D.S., and Carroll E. Palmer, M.D. *Milbank Memorial Fund Quarterly*, July 1938, p. 267.

An analysis of the enormous problem of providing dental care for elementary grade children.

PRESCHOOL

WHAT PROCEDURES CAN BE INSTITUTED IN THE INFANT AND PRESCHOOL LIFE OF THE CHILD FOR THE PREVENTION AND CONTROL OF DENTAL CARIES? Russell W. Bunting. *Journal of the American Dental Association*. March 1939. p. 375.

This article may be summarized in its conclusion: "Control the sugar habits of the child and you will most effectively protect him from dental caries."

THE NURSERY SCHOOL: WHAT IS IT? WHAT ARE ITS PROBLEMS? Natalie Haskins Blumenthal. *Hygeia*, June 1938, p. 558; July 1938, p. 647; August 1938, p. 754.

A series of articles on the nursery school. Traces the evolution of the nursery school in this country.

LOVE THEM AND TELL THEM SO. Helen Faw Mill. *Parents' Magazine*, July 1938, p. 17.

The story of parents who discovered that in their struggle not to spoil their children, they were impoverishing the children's emotional lives and giving them a sense of insecurity.

THE COST OF HABIT TRAINING. Len Chaloner. *Parents' Magazine*, August 1938, p. 17.

Points out the hazards of too much rigidity in child training.

"THERE WAS A CROOKED MAN." F. Josephine Wagner. *Hygeia*, June 1938, p. 495.

Practical suggestions about factors leading to good postural development in children.

• Thirty-seven years of public health nursing and social service by Anna B. Heldman was given recognition by the mayor of Pittsburgh, Pa., when he signed an ordinance on May 24, on petition of local citizens, changing the name of one of the streets in the Hill District where she works to Heldman Street. Miss Heldman has been personal service director at the Irene Kaufmann Settlement since 1918. She graduated from the Nurses' Training School of South Side Hospital in 1897, served as a nurse in the Spanish-American War, and in 1902 became a visiting nurse. She has participated in surveys of health and housing conditions in Pittsburgh and opened the first baby clinic in that city.

• The eighth Pan American Child Congress will be held in San Jose, Costa Rica, October 12-19. All American republics are planning to participate. Qualified individuals actively concerned with problems of child health and welfare may attend the congress individually as regular members. Child welfare institutions and agencies desiring to be represented at the sessions may send official members. The agenda of the Congress is divided into six sections: medical pediatric problems; surgical pediatric problems; child hygiene and eugenics; education; social welfare; and law, legislation, and sociology.

• The United States Public Health Service which has been under the administrative jurisdiction of the Treasury Department for nearly a century and a half was transferred from that department to the newly created Federal Security Agency on July 1, 1939. This change was part of the government reorganization plan submitted to Congress by the President on April 25, 1939, and which, passed by both houses, became effective July 1.

Under this plan, known as the "Reorganization Act of 1939," three units were set up—a Federal Security Agency, a Federal Works Agency, and a Federal Loan Agency, under which various "major independent establishments" in the government will be administered.

Under the Federal Security Agency are placed those agencies whose major purposes are "to promote social and economic security, educational opportunity, and the health of the citizens of the Nation." Besides the Public Health Service, the units grouped under this agency are the Social Security Board; the Civilian Conservation Corps; the Office of Education, formerly in the Department of the Interior; the United States Employment Service, formerly in the Department of Labor; and the National Youth Administration, formerly in the Works Progress Administration.

A brief history of the development of the Public Health Service and its activities by Brock C. Hampton is published in *Public Health Reports,* June 30, 1939, under the title, "The Public Health Service Leaves the Treasury Department."

• "Nursery education—today and tomorrow" will be the keynote of the biennial conference of the National Association for Nursery Education to be held at the Hotel Pennsylvania, New York City, October 25-28 inclusive. Sessions of special interest to nurses will

be the discussion of Nursery Education in Health Programs Under Public and Private Auspices, led by Dr. Ethel Dunham, director, Research in Child Development, U. S. Children's Bureau, and the presentation of "Implications of a Growth Study of Two Hundred Children," by Dr. Jean Macfarlane, associate professor of Psychology, University of California, Berkeley. A preliminary program will be sent upon request by Emma Johnson, Temple University, Broad and Montgomery Streets, Philadelphia, Pa.

• The officers of the Oregon State Organization for Public Health Nursing for 1939 are as follows: President, Mrs. Catherine Webster, Portland; first vice-president, Jane Hibbard, Oregon City; second vice-president, Nettie Alley, St. Helens; secretary, Aileen Dyer, Portland; treasurer, Mrs. Hazel Foeller, Portland.

• An appointment of interest to public health nurses is that of Bess Exton to the position as assistant in Health Education in the National Education Association. Miss Exton was the former executive secretary of the Genesee County Tuberculosis Association, Flint, Mich. Her new activities will include a field advisory service to educators in regard to health education problems.

• A public health nursing institute, sponsored by the School Health Service of the State Board of Education and the Division of Public Health Nursing of the State Board of Health, was held at Keene Teachers College, Keene, N. H., from July 10-24. The emphasis was on general public health nursing during the first half of the institute and on school nursing during the last few days.

• Ruth G. Taylor has been appointed a member of the staff of the International Health Division of The Rockefeller Foundation to be assigned to the Paris office as an associate of F. Elisabeth Crowell. Miss Taylor has an unusually rich background of experience including a year with the Grenfell Mission in the Newfoundland Hospital, and experience as a staff nurse in Kent County, Maryland; supervising nurse, University Clinics, University of Chicago; supervisor and director of public health nursing, Cattaraugus County, New York State; and district supervisor, Association for Improving the Condition of the Poor, New York City. For the past three years, she has been public health nursing consultant, Pacific Coast territory, U. S. Children's Bureau.

• The fortieth anniversary of the Nursing Education Division of Teachers College, New York, will be celebrated on October 13, with "Leadership in Nursing Education" as the theme of a special program. Nellie X. Hawkinson, president of the National League of Nursing Education, is chairman of the Alumnae Committee which is sponsoring an anniversary fund. The complete plans for the celebration are described in *The American Journal of Nursing*, July 1939, page 770.

• The summer institute on social and nursing problems in the control of syphilis and gonorrhea at the University of California at Berkeley was attended by 86 graduate nurses from 8 states and the Territory of Hawaii. The medical aspects of the control of these diseases were presented by Dr. Malcolm Merrill, chief of the Bureau of Venereal Diseases, California State Department of Public Health, and a staff of assistants; the nursing aspects by Mrs. Evangeline Morris of Simmons College, Boston, Mass. Represented in the group attending were public health nurses from many types of agencies, and nurses from institutional and private duty fields.

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